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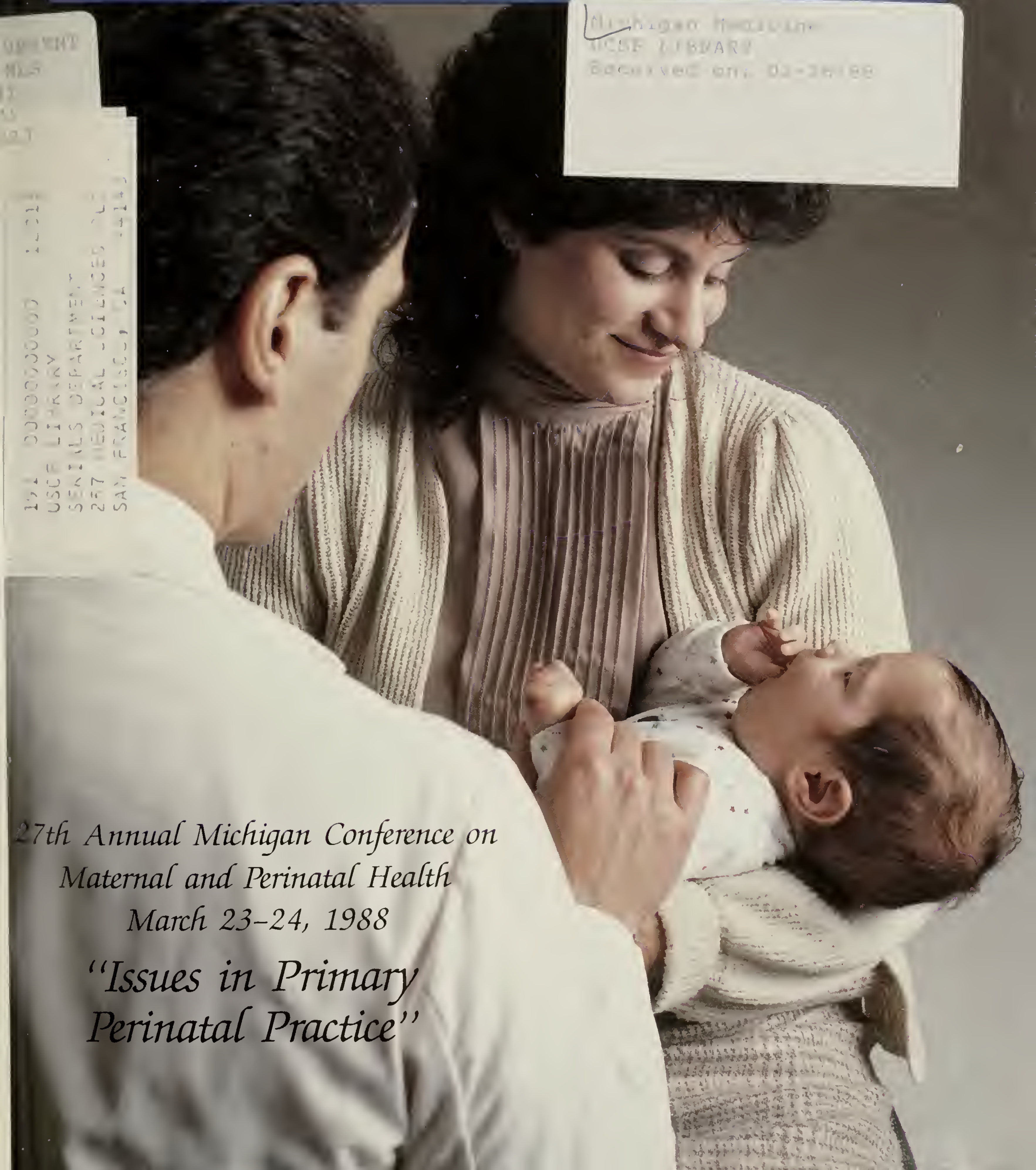

27th Annual Michigan Conference on
Maternal and Perinatal Health
March 23–24, 1988

"Issues in Primary
Perinatal Practice"

27th Annual Michigan Conference on
Maternal and Perinatal Health

March 23–24, 1988
Amway Grand Hotel, Grand Rapids

"Issues in Primary Perinatal Practice"

For details: Sherry Fent, Michigan State Medical Society, P. O. Box 950, East Lansing, MI 48826-0950
(517) 337-1351

MICHIGAN
MEDICINE
JANUARY 1988 VOL. 87 NO. 1

Special Report

"Issues in Primary Perinatal Practice" is the theme of this year's Michigan Conference on Maternal and Perinatal Health slated for March 23-24 at the Amway Grand Plaza Hotel in Grand Rapids. This month's Special Report features a complete preliminary program and registration form for this not-to-be-missed event. 4

Features

MSMS Annual Scientific Meeting highlights
A photo feature 12

Group practice physicians polled
Findings of a recent study reveal the attitudes and perceptions of group practice physicians toward organized medicine — By Gary G. Naeyaert and Patty M. Kosnar, Creative Media Inc. 14

Board of Medicine actions 16

Infant mortality
Michigan's high infant mortality rate has spurred several new Medicaid and public health programs — By Mary Anne Ford 19

Brain graft surgery performed
A look at Michigan's first brain graft surgery, performed at the U-M Medical Center in October — By Susan Berman 22

MSMS Judicial Commission report
The Commission examines income enhancement by physicians arising out of joint venture and other contractual relationships 29

Many challenges ahead in 1988
Board of Medicine administrator addresses some of the issues confronting the board in the months ahead — By Thomas J. DeKornfeld, MD 36

AMA reports available
Several reports considered at the AMA House of Delegates Interim Meeting in Atlanta now are available from MSMS 40

Departments

In my opinion
It's a sad commentary . . .
By John W. Hall, MD 2

Letters 3

Physicians in the news 39

Deaths 42

Category I courses 47

Meetings 49

Classified 51

Ad index 53

President's page
A just peace comes in stages
By Carl A. Gagliardi, MD 54

In next month's issue of *Michigan Medicine:* An in-depth look at AIDS. Included in the report will be a look at what MSMS is doing to educate physicians and the public about the deadly disease. Also included will be the official policy statements of the AMA regarding such issues as doctor/patient confidentiality and AIDS testing; interviews of leading Michigan physicians who work with AIDS patients; and a list of reference articles available to MSMS members on AIDS.

Cover photo by Kim Kauffman.

IN MY OPINION

"It is a sad commentary. . ."

By John W. Hall, MD

When we have medical crises—a cardiac arrest, a poisoning, a seizure—it is as American as apple pie to reach for a telephone and call for help. In the United States, we are blessed with excellent telecommunications. Almost every home, business and crossroad has telephone access to emergency help. With cellular technology, we all might soon carry a telephone with us.

The MSMS Advisory Committee on Communications and Professional Relations, with help from the MSMS staff, has developed *LifeGuide. LifeGuide* is a set of abbreviated first aid and CPR instructions that was prepared for publication in the Ameritech phone book. This handy guide was to serve as a readily available source of information. A similar guide has been published by Pacific Bell on the West Coast.

Lawyers then entered the picture. A lawyer for Ameritech demanded that MSMS had to be willing to indemnify Ameritech for all potential liability claims for use of the guide. Certainly, MSMS was reluctant to bear this responsibility alone. Yet, although chances of a suit are so slight and Ameritech is large enough to face this small exposure, it is unwilling to do so.

It is a sad commentary on our society and the dominant role that liability is playing in it. A valuable guide and potential lifesaving public service has been lost.

The Advisory Committee on Communications and Professional Relations still views *LifeGuide* as a valuable reference and sees its publication and distribution as an important public service effort. The Committee plans to publish the guide as a free-standing MSMS brochure, but the distribution can never match that of the phone book. But at least MSMS is willing to push forward with this project.

And so, because a lawyer "did his duty" and pointed out the possibility of liability, and, because a company was unwilling to assume "any" liability for the potential public service, this valuable joint venture is diminished. Hopefully, there will eventually be a public outcry which will force a change in our liability laws that will allow projects such as *LifeGuide* to be carried out in the future. ☐

Doctor Hall is a member of the MSMS Committee on Publications and of the MSMS Board of Directors.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserves the right to accept or reject advertising copy. Products and services advertised in *Michigan Medicine* are neither endorsed nor warranted by MSMS.

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BCBSM addresses lab ownership issue

Blue Cross and Blue Shield of Michigan (BCBSM) must disagree with the conclusion of an article ("Labs: Ownership is not the villain," by John W. Hall, MD, in the October, 1987 issue.

Our review of data including an actual review of records, has proven that there is a direct relationship between the ownership of laboratories and laboratory equipment outside of the office by physicians and overutilization of those facilities and the services they provide on the part of the same physicians.

Overutilization per se and inappropriate testing in general, certainly are a problem, but excessive and inappropriate testing based on financial incentive resulting from physician ownership of labs and lab equipment outside the office is even more of a problem.

BCBSM is convinced that testing becomes much more appropriate when the financial incentive is removed.

We're not opposed to physician ownership of labs and lab equipment, but we are opposed to physicians referring services to facilities outside of their office in which they have an ownership interest.

Larry J. Sell, MD
Senior Vice President
Health Care Affairs
Blue Cross/Blue Shield
of Michigan
Detroit

Malpractice crisis a top priority

I just read your November 17 *Medigram* regarding the "state's medical liability crisis." It is great that the State can allocate $17 million of the 1988 budget to fund the 5-year plan regarding the infant mortality rate.

You guys remind me of an 80-year-old landlord I once had. He discovered a leak in the ceiling, came in the house, plastered the crack, and stood back and admired his work. . . until the next time it rained. Once again, he had to fix the leak in the roof and plaster the ceiling.

Seventeen million dollars to help the women ineligible for Medicaid, increased Medicaid payments, new maternal support services? How much money would it take to try and keep the physicians in Michigan? How much money has gone into the FUNDS to work on the Mal-practice premiums?

Can't we find a CURE for the Mal-practice crisis and keep the physicians here in MICHIGAN, rather than spend $17 million to figure out how to help these people? How many physicians could we employ with the $17 million?

A very concerned medical assistant who loves her job and would like to remain in Michigan.

Nancy Siddall
Battle Creek

Lung Health Study results surprising

One-quarter of the 28,000 people recently screened during a nationwide Lung Health Study show evidence of chronic obstructive pulmonary disease (COPD) such as emphysema or bronchitis. That result is a surprising five to ten percent higher than expected.

COPD is the fifth leading cause of death in the United States. Cigarette smoking is the major contributor to the disease. Henry Ford Hospital is one of ten centers in the United States and Canada chosen as sites for the National Institutes of Health study which was set up to determine whether stopping smoking alone or in combination with a bronchodilator (medication in the form of an inhaler) will significantly slow the decline of lung function and reduce the incidence of pulmonary disease.

Other preliminary results of the Lung Health Study reveal that among those who show evidence of COPD, 40 percent are women, 30 percent are less than 45 years of age and most smoke an average of one-and-a-half packs of cigarettes a day.

For further information or to make an appointment to be tested, call (313) 876-1900.

Chris Kassab
Corporate Public Relations
Henry Ford Hospital

Goals and Objectives for the 27th Annual Michigan Conference on Maternal and Perinatal Health

"Issues in Primary Perinatal Practice"

March 23–24, 1988, Amway Grand Hotel, Grand Rapids

The perinatal health care professional attending this conference will have an opportunity to interact with a multidisciplinary faculty addressing "issues in primary perinatal practice." At the conclusion of the conference, the participant should be able to:

OBSTETRICAL CONCERNS

- be acquainted with some differences in Perinatal Health Care Systems.
- understand the necessity, timing and basic communication in facilitating referrals to regional centers.
- be familiar with some of the legalities of practicing primary perinatal medicine.
- comprehend vital aspects when stabilizing and transporting the critically ill mother.
- recognize importance of maternal assessment of fetal activity.
- understand the pathophysiology and treatment modalities in pregnancies complicated by hypertension.
- update the participant when caring for the diabetic pregnant woman.
- recognize the differences in antepartum testing, i.e. reliability, and "over" versus "under" utilization.
- familiarize oneself with modern technical advances in antepartum diagnoses.
- be aware of and be able to reliably detect multiple gestations.
- critically assess the caesarean section issue.
- appropriately diagnose and manage labor and premature labor.
- comprehend some of the moral, ethical and logistic problems in perinatal medicine.

PEDIATRIC CONCERNS

- recognize the role of interdisciplinary collaboration in providing the optimal milieu for the transport of a critically ill newborn.
- identify the clinical indications for transferring a newborn infant from a community hospital nursery to a tertiary facility.
- understand the essential elements in stabilizing a sick newborn prior to transport.
- recognize the potential benefits of back-transfer of a convalescing baby from a tertiary center to a community hospital.
- comprehend the pathophysiology, clinical manifestations, diagnosis and treatment of bacterial sepsis in the newborn.
- understand the intrauterine transmission of human immunodeficiency virus and the presentation of neonatal AIDS.
- identify the appropriate high-risk situation for Hepatitis B infection in the newborn and guidelines for isolation and treatment.
- understand the significance of neonatal TORCH infections and the applications and limitation of screening procedures.
- become aware of advances and indications for surfactant replacement therapy in newborns with respiratory distress syndrome.
- identify the ethical dilemmas associated with severe neonatal problems.

Wednesday Morning, March 23

7:30 a.m.

Registration, Continental Breakfast

8:15

GENERAL SESSION
Welcome: Carl A. Gagliardi, MD, Dearborn, President Michigan State Medical Society

Moderator: William Montgomery, MD, Immediate Past President, American Academy of Pediatrics; Clinical Professor, Department of Pediatrics, Wayne State University School of Medicine; Chairman, Child and Adolescent Health, Mount Carmel Mercy Hospital, Detroit

8:30

"Perinatal Health Care Systems"
Professor John M. Beazley, Department of Obstetrics and Gynecology, University of Liverpool, England

9:15

"Changing Trends in Perinatal Nursing Practice"
Rosanne C. Perez-Woods, RN, EdD, School of Nursing, Loyola University Medical Center, Chicago

9:45

Break

10:15

"Regional Perinatal Care and Health Care Systems"
John V. Hartline, MD, President, National Perinatal Association; Neonatologist, Bronson Methodist Hospital and Borgess Medical Center, Kalamazoo

10:45

"Legal Implications of Primary Perinatal Practice"
Mark H. Verwys, JD, Tolley, Fisher & Verwys, P.C., Grand Rapids

11:15

PANEL PRESENTATION WITH ALL SPEAKERS
Moderator: Doctor Montgomery

12 NOON

Adjourn to Lunch and Poster Presentations

The Maternal and Perinatal Health Conference Planning Committee

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Kenneth J. VanderKolk, MD, Co-chairman, Grand Rapids
John R. Addy, MD, Lansing
Silvio Aladjem, MD, Kalamazoo
C. Arch Brown, MD, Flint
David R. Calver, MD, Bloomfield Hills
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Ruth VandenBerg, RN, Grand Rapids
Paul von Oeyen, MD, Royal Oak
Daniel J. Wilhelm, MD, Port Huron
Lloyd A. Kammeraad, MD, ex-officio, Grand Rapids
Herman A. Ziel, Jr., MD, ex-officio, Perry

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity, the Michigan Conference on Maternal and Perinatal Health, meets the criteria for a maximum of 12 hours in Category I toward the requirements for Michigan licensure and of the Physician's Recognition Award of the AMA, provided it is completed as designed.

Wednesday Afternoon, March 23

Concurrent Sessions in A) Obstetrics and B) Pediatrics

	OBSTETRICS: “Problem Pregnancy”	**PEDIATRICS: “Neonatal Transport”**
	Moderator: Ronald Burkman, MD, Chairman, Department of Obstetrics and Gynecology, Henry Ford Hospital, Detroit	**Moderator: Donita Sullivan, MD**, Professor and Associate Chairman, Department of Pediatrics, University of Michigan Medical School
1:30	**“Stabilization & Transport of Critically-Ill Patients”** **Carol Harvey, RN**, Clinical Nurse Specialist, Department of Obstetrics and Gynecology, University of Tennessee, Memphis	**“Transport as a Model for Collaborative Practice”** **Suzanne Shelton, RN**, Director, Neonatal Services, Bronson Methodist Hospital, Kalamazoo
2:00	**“Maternal Assessment of Fetal Activity”** **Steve Gabbe, MD**, Professor and Chairman, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus	**“Indications for Neonatal Transport”** **Dharmapauri Vidyasagar, MD**, Professor, Department of Pediatrics; Head of Neonatology Unit, University of Illinois at Chicago
2:30	BREAK	BREAK
3:00	**“Primary Perinatal Care of Pregnancy-Induced Hypertension”** **Preston V. Dilts, MD**, Bates Professor and Chairman, Department of Obstetrics and Gynecology, University of Michigan Medical School	**“Stabilization for Neonatal Transport”** **Mary Bedard, MD**, Associate Neonatologist, Medical Director of Transport, Children’s Hospital of Michigan; Assistant Professor of Pediatrics, Wayne State University School of Medicine
3:30	**“Sharing Care of the Diabetic Pregnant Woman”** **Steve Gabbe, MD**, Professor and Chairman, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus	**“Transport is a Two-Way Street”** **Mary Scoblic, RN**, State Lead – Child Health, Michigan Department of Public Health, Lansing
4:00	QUESTION AND ANSWER SESSION WITH ALL SPEAKERS	QUESTION AND ANSWER SESSION WITH ALL SPEAKERS
4:30	ADJOURNMENT	ADJOURNMENT

Thursday Morning, March 24

Concurrent Sessions in A) Obstetrics and B) Pediatrics

	OBSTETRICS: “Prenatal Screening”	**PEDIATRICS: “Neonatal Infections”**
	Moderator: James Gell, MD, President, Michigan Section, American College of Obstetricians and Gynecologists, Bloomfield Hills	**Moderator: Samuel Sefton, MD**, President, Society of Michigan Neonatologists; Borgess Medical Center and Bronson Methodist Hospital, Kalamazoo
8:30	**“Use and Misuse of Antepartum Testing”** **Chang Y. Lee, MD**, Director, Department of Maternal-Fetal Medicine; Associate Director of Obstetrics/Gynecology and Reproductive Biology, Michigan State University College of Human Medicine	**“Bacterial Sepsis”** **Leonard Radecki, MD**, Butterworth Hospital, Grand Rapids
9:00	**“Technologies of Antenatal Diagnosis”** **Mark I. Evans, MD**, Director, Division of Reproductive Genetics, Wayne State University/Hutzel Hospital	**“AIDS in the Newborn”** **Flossie Cohen, MD**, Professor, Department of Pediatrics, Wayne State University; Director, Department of Clinical Immunology, Children's Hospital of Michigan, Detroit
9:30	**QUESTION AND ANSWER SESSION**	**QUESTION AND ANSWER SESSION**
9:45	**BREAK**	**BREAK**
10:15	**“Looking for More Than One”** **Robert Hayashi, MD**, Professor and Division Director, Maternal and Fetal Medicine, Department of Obstetrics and Gynecology, University of Michigan Medical Center	**“Hepatitis B in the Newborn”** **Roger Faix, MD**, Staff Neonatologist and Assistant Professor, Department of Pediatrics, University of Michigan Medical Center
10:45	**“Cancer Screening in Pregnancy”** **Bruce Drukker, MD**, Professor and Chairperson, Department of Obstetrics/Gynecology and Reproductive Biology, Michigan State University College of Human Medicine	**“TORCH Syndromes”** **Thomas C. Shope, MD**, Associate Professor, Department of Pediatrics and Communicable Diseases; Associate Professor of Pediatrics, Department of Pathology; University of Michigan Medical School; Associate Professor, Department of Epidemiology, University of Michigan School of Public Health
11:15	**QUESTION AND ANSWER SESSION**	**QUESTION AND ANSWER SESSION**

Thursday Morning, March 24, continued

11:30

Adjourn to Luncheon Meetings:
(all concurrent sessions)

"Stress and Burnout in Perinatal Care"
Joy H. Penticuff, RN, PhD, Associate Professor and Coordinator, High-Risk Perinatal Nursing Clinical Specialist Program, School of Nursing, University of Texas at Austin

"Caesarean Section: A Reappraisal"
Robert Hayashi, MD, Professor and Division Director, Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, University of Michigan Medical School

"Surfactant Replacement Therapy for RDS"
Dharmapauri Vidyasagar, MD, Professor, Department of Pediatrics; Head of Neonatology Unit, University of Illinois at Chicago

"Common Areas of Negligence in Fetal Monitoring"
Carol Harvey, RN, Clinical Nurse Specialist in Obstetrics, Department of Obstetrics and Gynecology, University of Tennessee, Memphis

"Control of Labor: How to Stop and Start"
Professor John M. Beazley, Department of Obstetrics and Gynecology, University of Liverpool, England

Thursday Afternoon, March 24

1:30

GENERAL SESSION:
"Ethics in Primary Perinatal Practice"
Moderator: Leonard M. Fleck, PhD, East Lansing, Assistant Professor, Medical Humanities Program, Michigan State University, College of Human Medicine

1:45

"Guidance for Families in Difficult Decisions"
John P. Minoque, MA, D.Min., Ethical Consultant to Maternal and Fetal Medicine, Northwestern Memorial Hospital, Chicago, Illinois

2:05

"Ethical Dilemmas in Reproductive Technology"
Mark I. Evans, MD, Director, Division of Reproductive Genetics, Wayne State University/Hutzel Hospital

2:25

Break

2:45

"Intrapartum Issues"
Professor John M. Beazley, Department of Obstetrics and Gynecology, University of Liverpool, England

3:05

"When an Ethical Dilemma Comes in the Door, Does Esprit d'Corps Go Out the Window?"
Joy Penticuff, RN, PhD, Associate Professor and Coordinator, High-Risk Perinatal Nursing Clinical Specialist Program, School of Nursing, University of Texas at Austin

3:25

PANEL PRESENTATION WITH ALL SPEAKERS
Moderator: Doctor Fleck

4:00

CONFERENCE ADJOURNS

27th Annual Michigan Conference on Maternal and Perinatal Health
March 23 & 24, 1988 Amway Grand Plaza, Grand Rapids

Wednesday Morning, March 23—General Session: "Issues in Primary Perinatal Practice

7:30	Registration, Continental Breakfast
8:15	Welcome
8:30	"Perinatal Health Care Systems"
9:15	"Changing Trends in Perinatal Nursing Practice"
9:45	Break
10:15	"Regional Perinatal Care and Health Care Systems"
10:45	"Legal Implications of Primary Perinatal Practice"
11:15	Panel Presentation with All Speakers
Noon	Adjourn to Lunch and Poster Presentations

Wednesday Afternoon, March 23—Concurrent Sessions in A) Obstetrics and B) Pediatrics

OBSTETRICS: "Problem Pregnancy"		PEDIATRICS: "Neonatal Transport"
"Stabilization & Transport of Critically-Ill Patients"	1:30	"Transport as a Model for Collaborative Practice"
"Maternal Assessment of Fetal Activity"	2:00	"Indications for Neonatal Transport"
Break	2:30	Break
"Primary Perinatal Care of Pregnancy-Induced Hypertension"	3:00	"Stabilization for Neonatal Transport"
"Sharing Care of the Diabetic Pregnant Woman"	3:30	"Transport is a Two-Way Street"
Question and Answer Session	4:00	Question and Answer Session
Adjournment	4:30	Adjournment

Thursday Morning, March 24—Concurrent Sessions in A) Obstetrics and B) Pediatrics

OBSTETRICS: "Prenatal Screening"		PEDIATRICS: "Neonatal Infections"
Registration, Continental Breakfast	7:30	Registration, Continental Breakfast
"Use and Misuse of Antepartum Testing"	8:30	"Bacterial Sepsis"
"Technologies of Antenatal Diagnosis"	9:00	"AIDS in the Newborn"
Question and Answer Session	9:30	Question and Answer Session
Break	9:45	Break
"Looking for More Than One"	10:15	"Hepatitis B in the Newborn"
"Cancer Screening in Pregnancy"	10:45	"TORCH Syndromes"
Question and Answer Session	11:15	Question and Answer Session
Adjourn to Luncheon Meetings	11:30	Adjourn to Luncheon Meetings

Thursday Afternoon, March 24—General Session "Ethics in Primary Perinatal Practice"

1:30	Introduction
1:45	"Guidance for Families in Difficult Decisions"
2:05	"Ethical Dilemmas in Reproductive Technology"
2:25	Break
2:45	"Intrapartum Issues"
3:05	"When an Ethical Dilemma Comes in the Door, Does Esprit d'Corps Go Out the Window?"
3:25	Panel Presentation with All Speakers
4:00	Conference Adjourns

Advance Registration For Michigan Conference on Maternal and Perinatal Health

Name____
(please print) (first) (initial) (last)

Address______________________________________

City____________________ State______ Zip______

County____________________ Phone (_____)__________

MSMS Member: Yes_____ No_____ Specialty________________

Nurse_____ Resident_____ Other__________________

Tuition Schedule

Physicians: $45 each Full-Day Session

Nurses: $35 each Full-Day Session

Others: $35 each Full-Day Session

Residents & Students: No Charge for Full-Day Sessions

Luncheon: $10 for All Registrants

Wednesday, March 23, 1988

☐ Full-Day Session $_____

☐ Luncheon/Poster Presentations $_____

☐ Choose one topic for afternoon Concurrent Session:
- ____ A: Obstetrics
- ____ B: Pediatrics

Wednesday Total = $_____

Thursday, March 24, 1988

☐ Full-Day Session $_____

☐ Choose one topic for morning Concurrent Sessions:
- ____ A: Obstetrics
- ____ B: Pediatrics

☐ Luncheon Meeting (indicate 1st & 2nd choices): $_____
- ____ Stress and Burnout
- ____ Caesarean Section: A Reappraisel
- ____ Surfactant Replacement Therapy
- ____ Negligence in Fetal Monitoring
- ____ Control of Labor

Thursday Total = $_____

Checks payable to:
Michigan State
Medical Society

GRAND TOTAL = $________

Please complete and mail with your check to MSMS, P.O. Box 950, East Lansing, MI 48826-0950, (517/337-1351). Confirmation of your registration will be sent to you with a reservation card.

ANNOUNCING

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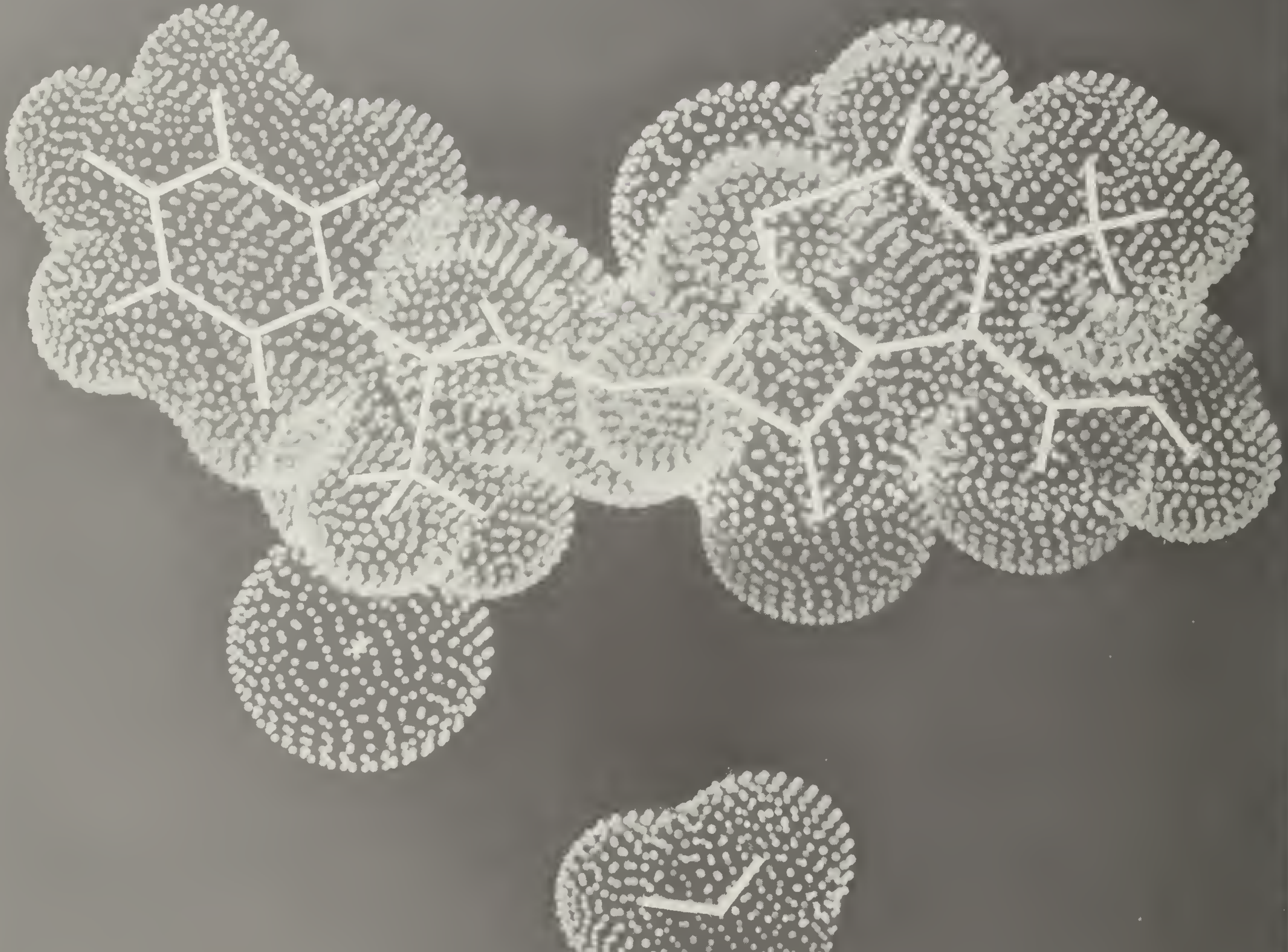
cephalexin hydrochloride monohydrate



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onvenient 500-mg b.i.d. osage and demonstrated ffectiveness for eatment of:

skin and skin structure infections*
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New hydrochloride salt form of cephalexin—requires no conversion in the stomach before absorption

Well-tolerated therapy

May be taken without regard to meals

r other indicated infections, 250-mg tablets available q.i.d. dosage

riced less than Keflex® (cephalexin)

ftab is contraindicated in patients with known allergy to the phalosporins and should be given cautiously to penicillin-nsitive patients.

nicillin is the drug of choice in the treatment and prevention streptococcal infections, including the prophylaxis rheumatic fever.

e to susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.
e to susceptible strains of *Escherichia coli*, *Proteus mirabilis*, and *Klebsiella* sp.
e to susceptible strains of group A β-hemolytic streptococci.

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(cephalexin hydrochloride monohydrate)

Summary: Consult the package literature for prescribing information.

Indications and Usage:

Respiratory tract infections caused by susceptible strains of *Streptococcus pneumoniae* and group A β-hemolytic streptococci.

Skin and skin structure infections caused by susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.

Bone infections caused by susceptible strains of *S aureus* and/or *Proteus mirabilis.*

Genitourinary tract infections, including acute prostatitis, caused by susceptible strains of *Escherichia coli*, *P mirabilis*, and *Klebsiella* sp.

Contraindication: Known allergy to cephalosporins.

Warnings: KEFTAB SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Keftab in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Keftab should be administered cautiously in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy and lactation. Cephalexin is excreted in mother's milk. Exercise caution in prescribing Keftab for these patients.
- Safety and effectiveness in children have not been established.

Adverse Reactions:

- *Gastrointestinal*, including diarrhea and, rarely, nausea and vomiting. Transient hepatitis and cholestatic jaundice have been reported rarely.
- *Hypersensitivity* in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis.
- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruritus, genital moniliasis, vaginitis/vaginal discharge, dizziness, fatigue, headache, eosinophilia, neutropenia, and thrombocytopenia; reversible interstitial nephritis has been reported rarely.
- Cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment.
- *Abnormalities in laboratory test results* included slight elevations in aspartate aminotransferase (AST, SGOT) and alanine aminotransferase (ALT, SGPT). False-positive reactions for glucose in the urine may occur with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

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MSMS Annual Scientific Meeting Highlights

The three-day MSMS Annual Scientific Meeting takes much planning and coordination. The 1987 event at the Hyatt Regency Dearborn was chaired by Rudi Ansbacher, MD, above right, and his Annual Scientific Meeting Planning Committee. Observing with more than the usual interest was Joan Stryker, MD, who will serve as 1988-89 chairman of the meeting.

At the MSMS registration desk, Arlyn Wilson and Joyce Crum, from righ provided physicians with course and luncheon tickets, and answered que tions. Approximately 1,000 physicians attended the 1987 event.

Carla Blacker, MD, Wayne State University, accepts the award from Doctor Ansbacher for the winning poster presentation at the Annual Scientific Meeting. Doctor Blacker was primary author for the presentation, entitled "Quidel Ovulation Test Kit Reliably Predicts Ovulation in Cloniphene-Induced Cycles."

QUIDEL OVULATION TEST KI ABLY PREDICTS
OVULATION IN CLOMI CYCLES.
C.M. Blacker, K.S. Moghis gsmann
Department of
Wayne State U

avid Rovner, MD, member, Annual Scientific Meeting Planning Com-
ittee, helps Macy Levine, MD, prepare slides for a course. Doctor
evine, clinical professor, Department of Medicine, University of Pitts-
irgh, was a speaker in the course on "Allergy, Asthma and Urticaria."

Donald Collison, MD, Detroit, brought his portable computer to class.

Robert K. Orr, Jr., DO, Lansing, supervises as physicians earn their accreditation in basic cardiac life support. All three sessions of the ever-popular course were sell-outs again this year.

Group practice physician study revealing

By Gary G. Naeyaert and Patty M. Kosnar

In order to more clearly understand the attitudes and perceptions of group practice physicians toward organized medicine, the Michigan State Medical Society and the American Medical Association, in conjunction with Creative Media, Inc. and Mitchell Group, Inc., conducted a study of Group Practice Physicians in Michigan. The results of this study will help enable organized medicine to become more responsive to the specific needs and concerns of the group practice physician.

Methodology

The survey was designed to discover differences in wants, needs and expectations of member vs. non-member group practice physicians with regard to organized medicine. Two-hundred-and-nine random telephone interviews were conducted with group practice physicians across the state. Forty-five percent were members of AMA and 55 percent were non-members. Fifty-four percent were MSMS members and 46 percent were non-members.

Processing

The telephone interviews were performed by the Mitchell Group, Inc.'s staff of professional interviewers in their central telephone facility in East Lansing, Michigan. The surveys were validated, edited, coded and keypunched by the Mitchell Group. Each question was cross tabulated by both member and non-member groups in order to ascertain differences between member vs. non-member responses.

Results-synopsis

Non-members

The survey results showed very interesting similarities and contrasts between member and non-member group practice physicians. Great differences were found in member vs. non-member's knowledge of benefits and services offered by organized medicine.

Although non-members feel lobbying and legislative affairs are important to group practice physicians, they are relatively unaware or less knowledgeable about the extensive services performed by organized medicine in this area.

Benefits such as the MSMS Annual Scientific Meeting, CME programs and MSMS publications, which are valued by members, were not considered as important to non-members. This could be due to the fact that non-members are less aware of the utility of these services.

Members of large group practices are less likely to be members of organized medicine. Only 13 percent of members reported being from groups of 21 physicians or more, compared to 84 percent of members who were from practices of 20 or less.

Non-members have not been in practice as long as members. Sixty-two percent of non-members reported being in practice for ten years or less.

Over 30 percent of non-members report that they have never been approached by organized medicine and consequently have not seriously considered membership. Likewise, over 20 percent have been approached within the last year regarding membership.

Very few suggestions were made by non-members for the improvement of benefits and services offered by organized medicine.

Members

Overall, members seem very satisfied with the benefits and services they receive from organized medicine. The vast majority were unable to suggest any additional benefits that would make membership more valuable to them.

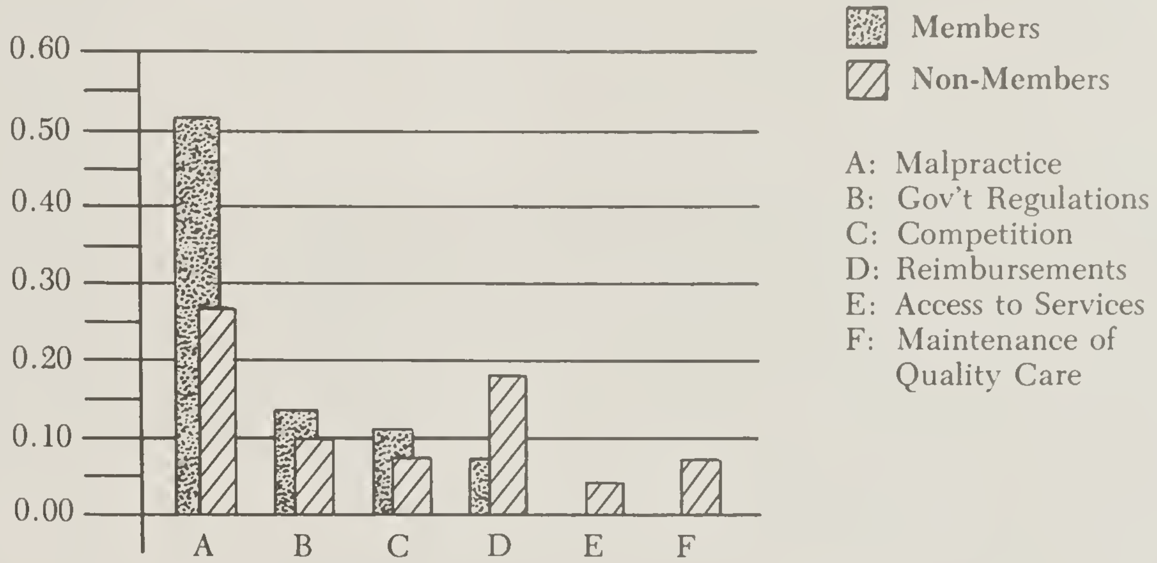
Members report a great deal of satisfaction with lobbying and legislative activities of MSMS. They feel they have been represented well by this organization, and this is their main reason for continued membership.

Members place a high importance on certain benefits offered by organized medicine. Among the most highly-rated benefits are the following:

- Lobbying and Legislative Affairs
- Malpractice Insurance

The authors serve on the staff of Creative Media Inc., East Lansing.

Number One Problem Facing Group Physicians



- AIDS Public Education
- MSMS Publications
- Annual Scientific Meeting/CME Programs

Members do not value these benefits as highly:

- Life Insurance
- Auto Leasing
- Credit Card Program
- Practice Management Services
- Patient Newsletters
- Physicians Placement Service

Many of these benefits are the type offered by individual group practices and therefore would not be considered important in physicians' decisions to continue membership.

A large number (76 percent) of members come from group practices in which all physicians are members of organized medicine.

Recommendations

The satisfaction shown by group practice physicians who are members of organized medicine indicate that no drastic changes are necessary to improve the utility or MSMS/AMA for potential members. It seems obvious that a comprehensive and targeted educational effort regarding programs and services should be undertaken and geared towards non-members.

Members are greatly satisfied with the representation they receive. Organized medicine has made great strides in the political arena. Nonmembers know of the importance lobbying plays, but seem to be unaware of what organized medicine has accomplished in this area.

Large group practices represent a great number of non-member physicians. These practices need to be introduced to the benefits organized medicine has to offer the large group, and to be convinced of the importance their support can play in legislation. Specific "large group benefits" may be needed to attract these physicians. An example of this may be reduced group rates.

Younger physicians also represent a large number of non-members who are less likely to join once they enter a group. These physicians need to be reached while in medical school or residency.

Over 50 percent of non-members report they have not been contacted or recruited by organized medicine in over a year. More frequent contact must be made with these doctors to remind them of the importance of membership.

We appreciate the opportunity to work with MSMS and AMA on this project. A more comprehensive analysis of the research study is available. For more information, contact the MSMS Membership Department. □

Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Donald F. Bosker, MD
Action, Date Taken: Reprimand, December 19, 1987
Reason: Incompetence

Name: Frank R. Hendricks, MD
Action, Date Taken: Revocation, December 19, 1987
Reason: Drug diversion

Name: Fredrick Alan Hutchinson, MD
Action, Date Taken: Six month & one day suspension, November 19, 1987
Reason: Substance Abuse

Name: John R. Mance, MD
Action, Date Taken: One year probation & reprimand, December 19, 1987
Reason: Failure to exercise due care

Name: Leslie D. McBeath, MD
Action, Date Taken: Suspend six months, one year probation & $1500 fine, December 19, 1987
Reason: Substance Abuse

Name: Mark Allen Menestrina, MD
Action, Date Taken: One year suspension, December 19, 1987
Reason: Substance Abuse

Name: George Michael Nowak, MD
Action, Date Taken: One year probation, December 19, 1987
Reason: Drug diversion/personal use

Name: Fredric J. O'Neill, MD
Action, Date Taken: Limited License & 1 year probation
Reason: Substance Abuse

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BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

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The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

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References:
1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 62-69, 1984.

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*Significantly greater than cimetidine smoker group ($P<.05$).

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Programs target Michigan's high infant mortality rate

By Mary Anne Ford

Michigan Department of Public Health (MDPH) Director Gloria Smith recently released Michigan's infant mortality figures for 1986. According to data compiled by the health department, Michigan's infant mortality rate remained at 11.4 deaths per 1,000 live births, the same as for 1985.

Infant mortality among blacks worsened in 1986, however, with statistics showing a statewide increase from 22.5 infant deaths per 1,000 live births to 23. Statistics also revealed an increase from 22.4 deaths per 1,000 live births to 24.3 in Detroit.

The release of Michigan's 1986 infant mortality statistics coincided with the beginning of new Medicaid and public health programs aimed at reducing the incidence of infant mortality among Michigan's low income families. Programs designed to increase Medicaid reimbursement to physicians providing prenatal and obstetrical service, to pay for deliveries through the MDPH Prenatal and Postpartum Care program, to provide for support services for low income pregnant women, and to increase outreach efforts to encourage pregnant women to seek early prenatal care, all began with the state's 1988 fiscal year.

In an effort to improve access to prenatal and obstetrical services for women on Medicaid, the Governor and the legislature allocated funds to increase reimbursement for deliveries by 30 percent and prenatal care services by 20 percent.

A new program to provide maternal support services for pregnant women on Medicaid also began November 1. The Maternal Support Services program uses providers certified by the Michigan Department of Public Health to provide non-medical services such as childbirth and parenting education, psychosocial and nutrition counseling assessments, and counseling and transportation to medical appointments.

> "Some counties cannot find a physician who will provide services because of the high malpractice premium associated with prenatal care."

Medicaid program officials estimate that nearly 50 percent of pregnant women on Medicaid may need support services beyond the prenatal care provided by participating physicians.

Maternal support services will be available only upon referral by a physician.

Referrals for maternal support services are made by letter to the local agency certified by the state. A list of certified maternal support service providers can be obtained by contacting: Special Programs Section, Bureau of Program Policy, Medical Services Administration, P.O. Box 30037, Lansing, MI 48909.

Changes in federal law permit Michigan to expand Medicaid eligibility for pregnant women whose incomes are within 100 percent of the federal poverty level, rather than the current 65 percent. This change took effect January 1, 1988.

The Michigan Department of Public Health is also expanding its programs aimed at reducing infant mortality, as implementation of a five-year plan recommended by a Task Force on Infant Mortality begins.

Although state officials are optimistic about the effect of new programs, they agree with MSMS that long-term solutions to the infant mortality problem need to address the medical liability issue.

In her announcement of new infant mortality statistics and programs, MDPH Director Smith said liability affects access to prenatal care, noting that "some counties cannot find a physician who will provide services because of the high malpractice premium associated with prenatal care."☐

Ms. Ford is chief of State Government Affairs for MSMS.

REFERENCE GUIDE TO PRENATAL AND OBSTETRICAL CARE COVERAGE

This chart is provided as a quick reference to programs and services for low income pregnant women. Further information about Medicaid programs can be found in medical assistance program bulletin 5310.1-87-14, which is available from Mary Anne Ford at MSMS. For additional information about the Prenatal/Postpartum care program, contact your local health department.

Program	Eligibility Criteria	Services Covered	Contact
Medicaid	Pregnant women whose incomes are within the federal poverty level may be eligible for Medicaid. In January, 1988, the poverty level is $616 for a family of two; $775 for a family of three; and $993 for a family of four. Family size includes unborn children.	• prenatal care visits • laboratory tests and x-rays • prenatal vitamins • delivery • hospital care • postpartum care	Your patient should contact the local office of the Department of Social Services for a Medicaid application
Medicaid Maternal Support Services	Screening and referral by the physician or certified nurse midwife responsible for the patient's prenatal care.	When provided by a Maternal Support Services Provider who is certified by the Michigan Department of Public Health, the following services are covered: • childbirth and parenting education • psychosocial and nutrition assessment and counseling • transportation	A letter of referral should be sent to the local Maternal Support Services Provider
Prenatal/Postpartum Care Program (PPC)	The PPC Program covers pregnant women with incomes up to 185 percent of the federal poverty level, who do not qualify for Medicaid or other health insurance programs.	• prenatal care visits • initial laboratory work • prenatal vitamins • delivery • childbirth education • one postpartum visit • additional special services, which will vary among local health department jurisdictions	The local health department
Prenatal/Postpartum Care Program Maternal Support Services	Maternal Support Services are available to women in certain counties where infant mortality rates are especially high. In these targeted counties, screening and referral by the physician or certified nurse midwife overseeing care is necessary.	The services covered under the PPC Maternal Support Services program are the same as the services available to eligible Medicaid clients.	The local health department

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U-M Medical Center performs state's first brain graft

By Susan Berman

Part I: Surgery offers hope

The University of Michigan Medical Center has joined other United States centers in investigating the dramatic surgery that has reportedly brought clinical improvement to sufferers of Parkinson's disease.

A team of four physicians performed the state's first brain tissue graft on a 55-year-old Detroit woman with long-term, incapacitating parkinsonism. Participating in the procedure were Terry W. Hood, MD, assistant professor in the Department of Surgery, Section of Neurosurgery; Norman W. Thompson, MD, professor in the Department of Surgery and chief of the Endocrine Division; and Harry S. Greenberg, MD, and John B. Penney, MD, both associate professors in the Department of Neurology.

The procedure grafts tissue for a patient's own adrenal medulla (which produces dopamine, among other substances) to the caudate nucleus of the brain.

The theory behind the autologous transplant is that the adrenal tissue will continue to produce dopamine once grafted to its new site in the brain. This dopamine will then compensate for the neurotransmitter no longer produced by degenerated substantia nigral cells. These cells, though fibers to the striatum, signal the production of dopamine.

In parkinsonism, the lack of dopamine due to brain cell degeneration seems to be responsible for the disease's uncontrolled body movements, tremors and rigidity. Parkinsonism affects around one million people in the United States.

Replacing dopamine through administration of levadopa, begun in the 1960s, is virtually the only available treatment for parkinsonism. Over time, this therapy becomes less effective in many patients, perhaps due to patients' physiological reactions to the drug or to further degeneration of substantia nigral cells. Another drawback of this treatment is that levadopa causes severe reactions such as hallucinations or convulsions in some patients.

> "The surgery itself is low risk, and given the desperate condition of the patient, offers hope in an otherwise hopeless situation."

Surgical technique

The surgical technique at the U-M Medical Center involves two stages. First, surgeons remove one of the patient's adrenal glands and dissect the medulla tissue lying in the central portion. Second, a frontal incision is made just behind the patient's hairline and a craniotomy flap formed.

The actual incision in the brain follows a whitematter track to the fluid-filled chamber. Small bits of adrenal medullary tissue, totaling perhaps 500 mg, are grafted onto the surface of the caudate nucleus and held in place by titanium clips.

According to Doctor Hood, several weeks are required for the graft to develop its blood supply and begin to produce dopamine. The hope is that dopamine will be spread throughout the brain by the cerebral spinal fluid bathing the brain tissue.

The procedure used by the Michigan team is very similar to that pioneered by physicians at Hospital de Especialidades Centro Medico "La Raza," Mexico City, earlier in 1987. (See History of brain graft surgery.) University researchers in Ann Arbor have been investigating this approach to treating parkinsonism for two years.

"The surgery itself is low risk," said Doctor Greenberg, "and given the desperate condition of the patient, offers hope in an otherwise hopeless situation."

The first patient to undergo this procedure at the University of Michigan Medical Center has suffered from Parkinson's disease for 20 years. Over the past three to four years, her condition deteriorated to where she has no semblance of normal life. Her particular form of parkinsonism could not be controlled by medication due to the fluctuation of

The author is a Grosse Pointe Park freelance writer.

symptoms. Periods of extreme rigidity would be followed by excessive, uncontrolled movements, and she would endure this cycle several times a day.

The patient underwent the four-and-a-half hour operation in late October and tolerated the surgery extremely well. She was discharged about two weeks following surgery. At this time, there was no change in the symptoms of her parkinsonism; however, Doctor Hood said that no improvement was anticipated for another two to four weeks. The researchers are monitoring the patient's clinical condition and biochemical data to evaluate the effects of the implant.

The Medical Center team is applying the criteria for patient selection to other victims of Parkinson's disease to identify up to five more candidates for the brain graft surgery.

The criteria require that patients be less than 60 years old, have no other medical illness, have a clear diagnosis of Parkinson's disease agreed upon by several neurologists, as well as be refractory to control symptoms through medication.

History of brain graft surgery

Transplantation of adrenal medullary tissue to the striatum for treatment done of Parkinson's disease done in 1982 was reported in the *Journal of Neurosurgery* in February 1985. These first clinical trials were carried out by Erik-Olof Backlund and colleagues in Stockholm. In two case reports, there was some evidence that surgery had improved the patients' conditions, albeit marginally.

Over the next few years, other centers throughout the world performed autogologous brain graft surgery, using a variety of techniques on a limited number of patients, with equivocal results.

Then, at The Schmitt Neurological Sciences Symposium in Rochester, New York, last summer, Rene Drucker-Colin, MD, of La Raz, Mexico City, reported that brain grafts of adrenal medullary tissue had produced dramatic clinical improvement in parkinsonism patients. In the words of an attendee, this announcement turned the symposium into a "media event" and coverage in the electronic and print media followed.

Yet the reasons for patients' improvement remained unclear. Other researchers have raised questions about patient selection (were they indeed suffering from Parkinson's disease?) and control of evaluations with the La Raza patients reviewed.

Some participants at the Rochester meeting felt that the surgery itself may be responsible for alleviating parkinsonism symptoms, perhaps by somehow releasing trophic factors that stimulated filtering cells. There was no evidence in the Mexican trials that levels of dopamine in the brain increased.

The first United States experiments with human brain implant surgery for Parkinson's disease were done at Vanderbilt University Medical Center. George Allen, MD, from Vanderbilt said in the July 1987 issue of *Science*: "We see change in the direction of improvement but it is too early to make definitive statements."

Continued on next page

BRAIN SURGERY/Continued

Alternative therapies

Among other surgical treatments for Parkinson's disease being explored is the transplantation of healthy substantia nigral cells from a donor.

Rats with drug-induced parkinsonism have shown significant improvement when functioning substantia nigral cells are implanted in their brains. However, for human subjects, the ethical issues surrounding obtaining fetal substantia nigral cells for implantation has inhibited research with this approach.

With donor cells the questions of graft rejection and long-term immunosuppression are raised. While implanting a patient's own adrenal tissue avoids these problems, how the brain will ultimately deal with the implanted cells is unknown.

In addition to surgical therapies for Parkinson's disease, drugs with the potential to block the destruction of the substantia nigral cells are being tested. It is not clear why these cells die causing Parkinson's disease, but some suspect an environmental toxin may be partly to blame.

The hope is that by rigorous controls on patient selection, coupled with documented biochemical data and clinical evaluation, the true value of this revolutionary surgery can be judged.

The potential for surgical intervention into the once inviolate brain for other neurological diseases such as Alzheimer's, has excited researchers.

As Doctor Hood says, however, "Research into the causes of other neurodegenerative diseases will need to equal that available in Parkinson's disease so that in time, if the implants work, we can determine what sorts of implants might work with other diseases."

"The hope is that by rigorous controls on patient selection, coupled with documented biochemical data and clinical evaluation, the true value of this revolutionary surgery can be judged."

Part II: Effects of surgery questionable

The early, hopeful results of brain graft surgery need to be followed by carefully designed and executed research protocols. This is why University of Michigan Medical Center researchers are proceeding with the experimental surgery on sufferers of Parkinson's disease.

While reports on the results of this pioneering procedure have generated much excitement, true research and evaluation are just beginning. "We have heard the talks and seen the videotapes," said Doctor Greenberg, "but nothing definitive has appeared in the neurological literature."

The research protocol used by University of Michigan physicians includes stringent selection of patients and thorough baseline evaluations prior to surgery. In addition, the extremely experimental nature of the operation is explained to patients and the fact that chances for improvement are at best around 50 percent.

Doctor Hood said that they will measure levels of dopamine and its metabolites, plus a host of other compounds, to determine if the graft is working and why. An indwelling ventricular catheter allows drawing of spinal fluid samples adjacent to the graft. In addition, positron emission tomography (PET) will be used to observe the metabolic activity of the grafts.

A puzzling finding with other implant patients has been that, despite some evidence of clinical improvement, dopamine levels do not appear to have increased in the cerebrospinal fluid or in the brain.

Also unanswered is whether the grafted tissue survives. A report in *Science* (July 1987) on the presentation of the Mexican pa-

Continued on page 26

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tients at the Rochester symposium showed slides of the implant area of a patient who had died. The grafted adrenal cells did not appear to have survived but the patient was reported to have been experiencing improvement of his symptoms until his death.

Data obtained from the University of Michigan Medical Center studies, as well as from studies underway around the world, will eventually either place brain grafts among the therapeutic modalities for parkinsonism or prove it to be a tantalizing, but disappointing, avenue of research.

Part III: Too early for human experimentation?

The range of views among Michigan researchers on the advisability of brain graft surgery in human subjects reflects international differences of opinion on this experimental procedure.

In general, the Michigan neurologists and neurosurgeons interviewed are intrigued with the possibilities opened by brain implants for treating conditions where malfunction or degeneration of brain tissue is involved, but have varying opinions as to whether the time has come for human experimentation.

Henry Ford Medical Center staff James Ausman, MD, and Jay Gorell, MD, chairmen of the Departments of Neurosurgery and Neurology, respectively, have extensively reviewed the world literature and attended the Rochester symposium. Doctor Ausman notes impressive results with fetal implants but less complete evidence with adrenal implants.

> **"The range of views among Michigan researchers on the advisability of brain graft surgery in human subjects reflects international differences of opinion."**

"So far, there is no evidence that the tissue survives for long periods or that it produces chemicals," commented Doctor Ausman.

Differences in surgical techniques and patient selection also make it difficult to evaluate and compare results with the procedure.

Doctor Gorell stated that while "opinion is divided on whether it is the time to do this surgery on humans. . . clearly momentum is building to do the surgery.

"At Henry Ford our excitement is tempered by the feeling that more work needs to be done," he said.

Doctor Gorell, along with several other physicians interviewed, made the point that more research is needed into the causes of parkinsonism, as well as of other neurodegenerative diseases.

Robert Lisak, MD, chief of neurology at Wayne State University School of Medicine, feels that all human work is premature.

"We don't know enough about the disease and most reports have been spotty," said Doctor Lisak. He is in agreement with an editorial in the October issue of the *Annals of Neurology* calling for a moratorium on human trials.

The editorial, coauthored by Robert Joynt, MD, PhD, and Don Marshall Gash, PhD, from the University of Rochester School of Medicine, looks at the varying results so far, "the extent of surgery required, disagreement on the optimal site of tissue placement, and as yet poorly-understood mechanism of action of the graft" and asks "whether we are ready for this procedure."

In an upcoming issue of the Michigan Parkinson Foundation newsletter, Peter LeWitt, MD, associate professor of neurology and psychiatry at Wayne State University School of Medicine, comments on the place of brain grafts among therapies for Parkinson's disease.

Doctor LeWitt writes, "The standard for judging this procedure is against the effectiveness of medications both currently available and those which will be produced in the near future. New medications as well as delivery systems are under development. Until then, the best approach is wait and see."□

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However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:
Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

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BRS-TG:L73B Date of issuance Apr. 1987

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Fruits, vegetables, and whole-grain cereals such as oatmeal, bra and wheat may help lower the ris of colorectal cancer.

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MSMS Judicial Commission report

Editor's note: At the direction of the MSMS Board of Directors, *Michigan Medicine* prints the following report from the MSMS Judicial Commission, prepared with the assistance of legal counsel. The report was received for information by the Board November 18, 1987.

The MSMS Board referred to the MSMS Judicial Commission the ethical question of income enhancement by physicians arising out of joint venture and other contractual relationships.

Specifically, the Board requested the Judicial Commission to consider and report on the ethics of physicians owning financial interests in contracts or organizations involved in providing health care services. The question presented to the Judicial Commission is generic; no specific facts regarding any individuals or structures have been presented.

The American Medical Association has established guidelines. The Council on Ethical and Judicial Affairs (formerly Judicial Council) of the AMA has adopted the following position:

"Physician ownership interest in a commercial venture with the potential for abuse is not in itself unethical. Physicians are free to enter lawful contractual relationships, including the acquisition of ownership interests in health facilities or equipment or pharmaceuticals. However, the potential conflict of interest must be addressed by the following:

"1. The physician has an affirmative ethical obligation to disclose to the patient or referring colleagues his or her ownership interest in the facility or therapy prior to utilization.

"2. The physician may not exploit the patient in any way, as by inappropriate or unnecessary utilization.

> **"The physician has an affirmative ethical obligation to disclose to the patient or referring colleagues his or her ownership interest in the facility or therapy prior to utilization."**

"3. The physician's activities must be in strict conformance with the law.

"4. The patient should have free choice either to use the physician's proprietary facility or therapy or to seek the needed medical services elsewhere.

"5. When a physician's commercial interest conflicts so greatly with the patient's interest as to be incompatible, the physician should make alternative arrangements for the care of the patient." (Source: Judicial Council Report C, I-84, "Conflict of Interest Guidelines")

The Judicial Commission adopts these guidelines. Unfortunately, the provision of subparagraph 3 that "the physician's activities must be in strict conformance with the law" presents substantial uncertainty for Michigan physicians.

Section 16221 of the Public Health Code provides as follows: ". . . the board shall proceed under section 16226 when the board finds. . . unprofessional conduct, consisting of any of the following: directing or requiring an individual to purchase or secure a drug, device, treatment, procedure or service from another person, place, facility, or business in which the licensee has a financial interest . . ." (Source: MCLA 16221(1)(e)(iv))

Section 16226 sets forth the sanctions that may be imposed upon a licensee: "After finding the existence of one or more of the grounds for board action listed in section 16221, a board shall impose one or more of the following sanctions for each violation: (Subsection (e)(iii) or (e)(iv)) reprimand, fine, probation, suspension, revocation, limitation, or restitution."

Section 16221 (e) (iv) has not been interpreted by any appellate court in Michigan. Thus, there is no guiding judicial precedent. The Michigan Attorney General and an Oakland County Circuit judge have opined on the meaning of the subsection.

The Michigan Attorney General, in Opinion No. 5229, rendered September 30, 1977, confronted the issue prior to the enactment of the Public Health

Continued on next page

Code and the specific subsection at issue.

In Opinion No. 5229, the Attorney General opined that a referral by a physician of a specimen of his patient to a clinical laboratory which the physician owns or in which he has a financial interest is a violation of the law only if the remuneration received from the interest is in fact a kickback, a rebate or a form of fee-splitting.

The Attorney General further opined that where a physician has a bona fide ownership interest or a bona fide financial interest in a clinical laboratory and the physician's rate of income on his investment in a clinical laboratory is not tied to the number of referrals made by him nor to a percentage of the income derived from these referrals, there is no violation of the law. Since Attorney General Opinion No. 5229 preceded the applicable statute, it provides no clarification.

In Opinion No. 5498, issued June 8, 1979, the Michigan Attorney General opined on the meaning of the specific statute at issue. In this Opinion, the Attorney General rendered the following opinions:

"1. A licensed health professional is prohibited from directing or requiring an individual to purchase or secure a drug, device, treatment, procedure or service, *even if necessary*, from a person, place, facility or business in which the licensed health professional has a financial interest." (Emphasis added.)

"2. A licensed health professional has a "financial interest" in a clinical laboratory if he or she is the proprietor, a partner, a limited partner, a shareholder, or has a similar business interest in the clinical laboratory.

"3. Violation of the prohibition against a licensed health care professional having a financial interest in a clinical laboratory is *not avoided by disclosure* of the interest to the individual being directed or required to obtain a drug, device, treatment, procedure or service." (Emphasis added.)

Judge Alice L. Gilbert, Oakland County Circuit judge, rendered an Opinion interpreting the applicable statute on October 6, 1982, in *Melvin Lester, MD, and Martin Klein, MD, vs. Frank Kelley, Attorney General of the State of Michigan, et al,* Oakland County Circuit Court Case No. 79-189, 821-CZ.

In the *Lester* case, the plaintiffs argued that the applicable section was unconstitutionally vague and therefore void. Judge Gilbert held to the contrary: the statutory provision is not constitutionally vague and is therefore valid. The word "direct" in the statute was the primary focus in the *Lester* decision. Judge Gilbert, in analyzing the meaning of the word "direct," stated as follows:

"It is evident that while plaintiffs wish to construe the language as ambiguous and indistinct, the literary emphasis provided by both the Webster's and Random House dictionaries is clearly upon the elements of *commanding or ordering* a particular action." (Emphasis added.)

No appeal was taken in the *Lester* case. The Opinion of a

Continued on page 32

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ETHICS/Continued

County Circuit judge does not constitute binding precedent. Therefore, physicians may not rely upon Judge Gilbert's narrow interpretation of the word "direct."

Senate Bill 59 was introduced in the Michigan Legislature earlier this year. This proposed legislation would strike a balance between the absolute restrictions under current Michigan law and no restrictions at all.

Exceptions were specifically provided in Senate Bill 59 for: (1) ownership of publicly-traded stock in a health facility; (2) facilities owned solely for the licensees' own patients; (3) interests in real property as a landlord of a health facility unless rent is determined by profits or referrals; (4) employment or affiliation with a hospital; and (5) referrals in the context of HMOs, PPOs, IPAs and other pre-paid systems. Even if no exclusion was applicable under the Bill, such referrals would still not be illegal (except in one instance) if full disclosure was made to the patient and third-party payors, authorization was given for periodic utilization review audits and a detailed accounting system was applicable.

The single area which would have remained illegal under the Bill, without exception, was an arrangement in which a licensee acquired a financial interest under an agreement which based the licensee's return on investment on the number or value of referrals.

Senate Bill 59 did not pass; it

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was not even reported out of the Senate Health Policy Committee. Multiple interest groups testified for and against the Bill. There is little likelihood that such a compromise bill will pass the Legislature in the near future.

The Attorney General has commenced administrative complaints against physicians before the Department of Licensing and Regulation, Board of Medicine, under Section 16221 (e) (iv). The complaints relate to alleged ownership interests by certain physicians in Metric Medical Laboratories. The status of these administrative complaints is not specifically known to the Judicial Commission but it is understood that the Board of Medicine will not render any opinion as to the meaning of the statute.

Section 16221(e) (iv) is unique to Michigan. No other state has such a restrictive statute. Lack of judicial precedent interpreting the statute creates legal uncertainty. There is no expectation that legislative clarification will be forthcoming in the near future.

Whether a particular joint venture arrangement is ethical within the AMA Guidelines depends, in part, upon the interpretation of the law. Michigan law is unique and uncertain. The application of this statute to any specific set of facts establishing a joint venture arrangement for the provision of medical services in which a physician has a financial interest should be left to the individual physician based upon sound legal advice. ☐

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Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan Oecember Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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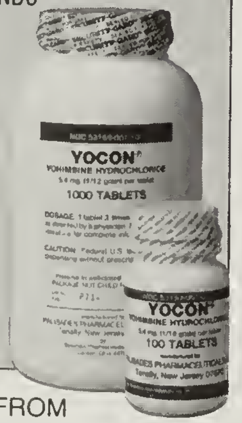

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BOARD OF MEDICINE

Many challenges are ahead in 1988

By Thomas J. DeKornfeld, MD

It is timely now to address some of the issues that confront the Board in the year of grace 1988.

The biggest single problem is the lack of adequate communication between the Board of Medicine and the practicing physicians in the state. In fact, it can be said without much doubt that the Board of Medicine is one of the best-kept secrets in Michigan.

This attitude is most regrettable, as the Board is a vital force in the state's medical scene.

It has a dominant role in determining who will practice here and, perhaps more importantly, who no longer will practice here.

It is the Board and the Board alone which stands between the practitioner and an angry consumer. It is the Board and the Board alone that has the statutory power to discipline the errant physician and to protect the good name of the huge majority of physicians who practice according to the finest traditions of our noble profession.

Why is it, then, that so very few of you ever contact the Board unless you have a complaint to make or you want something done that the law does not allow the Board to do?

I gratefully acknowledge the cheerful and generous way in which a number of you have agreed to assist the Board when called upon. But in my year-and-a-half with the Board I recall only a handful of incidents when one of you contacted the Board spontaneously with a suggestion, a recommendation, an offer of assistance or even a kind word to express your satisfaction with the task the Board has to perform and the fairness and decency with which the Board approaches its difficult and sensitive disciplinary obligations.

It may be helpful if I draw a clear distinction between the roles and functions of the Bureau of Health Services, the Michigan Board of Medicine and myself.

"New Year's Eve is over, but it is not too late to make another New Year's resolution. Resolve to contact the Board, to help the Board, to make suggestions to the Board and, once in a while, to pat the Board on the back."

The Bureau of Health Services is one of the major components of the Department of Licensing and Regulation (L&R). It is charged with providing the structure within which the licensing and regulation of the licensed health professionals takes place. It is through the Bureau that the funding of all the boards is accomplished and it is the Bureau which provides the staff, both licensing and regulatory, which makes the system work.

All the staff in the office, all the investigators, all the supervisory personnel, work for the Bureau. With very few exceptions, these people are in the civil service and are, without exception, hard-working and dedicated public servants. They are the backbone of government who serve the public, frequently under difficult and trying circumstances. They are good people and the public does not even begin to know how much it owes to them.

The Board of Medicine consists of 14 members appointed by the Governor. Ten are physicians, three are public members and one represents the Physician Assistant Task Force. The Board meets monthly and transacts business of both a licensing and regulatory nature. Its primary function is to promulgate the rules under which physicians are licensed and to discipline the physicians who violate the Public Health Code.

The Board also reviews applications from hospitals and schools that wish to be approved by the Board and where such approval is required for trainees of those institutions to be licensed. The Board members do not live in Lansing and you can't "speak" to them unless you attend one of their monthly meetings.

If you call the Board, you will talk to one of the persons in the Board office, whose efforts and

Continued on page 4

Doctor DeKornfeld is administrator, Michigan Board of Medicine.

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†See Warnings and Precautions.

Please see brief summary of prescribing information on the next page. 0453S7

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Professional Use Information

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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%).

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 9/86

See complete Professional Use Information before prescribing.

References: 1. Schroeder JS: Mod Med 1982;50(Sept):94-116. **2.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **3.** O'Rourke RA: Am J Cardiol 1985;56:34H-40H. **4.** McCall D, Walsh RA, Frohlich ED, et al: Curr Probl Cardiol 1985;10(8):6-80. **5.** Frishman WH, Charlap S, Goldberger J, et al: Am J Cardiol 1985;56:41H-46H. **6.** Shapiro W: Consultant 1984;24(Dec):150-159. **7.** O'Hara MJ, Khurmi NS, Bowles MJ, et al: Am J Cardiol 1984;54:477-481. **8.** Strauss WE, McIntyre KM, Parisi AF, et al: Am J Cardiol 1982; 49:560-566. **9.** Feldman RL, Pepine CJ, Whittle J, et al: Am J Cardiol 1982;49:554-559.

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PHYSICIANS IN THE NEWS

Steinhauer

Popovich

Slovis

O'Brien

Saleh

Saper

James W. McGee, MD, Kalamazoo, is the developer of I/PACS, the system awarded the 1987 Outstanding Achievement Award of the Voice Input/Output Society. I/PACS is the only hospital radiology computer system using voice to text technology, providing instant access to reports and decreasing patients' length of stay.... **Two Henry Ford Hospital physicians** have been honored with the designation of endowment grants from the Henry Ford II estate in their names. Henry Ford Hospital recently received a $1 million endowment grant from the Ford Motor Company Fund as a memorial to Henry Ford II, former board chairman of the company who died from pneumonia September 29. The first two grants made from the endowment income each year will be designated Henry Ford II Grant in Honor of **Doctor Bruce W. Steinhauer, MD**, Detroit, (Mr. Ford's personal physician) and Henry Ford II Grant in Honor of **Doctor John Popovich Jr., MD**, Detroit, (director of intensive care).... **Thomas L. Slovis, MD**, Birmingham, received special recognition from his peers during the convocation ceremonies at the annual meeting of the American College of Radiology, for his outstanding contributions to the field of radiology. Slovis was named as one of the 104 fellows by the college's Board of Chancellors.... **James G. O'Brien, MD**, East Lansing, professor and associate chairperson of Michigan State University's Department of Family Practice, College of Human Medicine, has been cited for his work with the state's older population by the Michigan Society for Gerontology. He was presented with the 12th annual V.K. Volk Award for health services at the organization's annual conference at MSU.... **Abdelaziz A. Saleh, MD**, Pontiac, an obstetrical and gynecological resident at Pontiac General Hospital, recently was honored as the outstanding junior fellow research presenter at the District V Annual Meeting of Obstetricians and Gynecologists in Indianapolis. Doctor Saleh, a first-year resident, presented his prize-winning paper, "Homostatis in Hypertensive Disorders of Pregnancy," in competition with other papers from District V. A panel will review the award-winning paper from all 10 districts and select two to be presented and honored at the annual meeting of the college in May. ...**Joel R. Saper, MD**, Ann Arbor, author of *Help for Headaches* and medical director of the Michigan Headache and Neurological Institute, Ann Arbor, was a guest on Cable News Network's "Sonya Live in L.A." show November 18. Doctor Saper discussed *Help for Headaches*, his fifth and latest book. ☐

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The following reports were considered at the AMA House of Delegates Interim Meeting in Atlanta, December 6-9, 1987. Copies are available by contacting Arlyn Wilson, MSMS Department of Communications, 120 W. Saginaw St., East Lansing, MI 48823, (517) 337-1351.

Reports of the AMA Board of Trustees

Report C--Trends in Health Delivery Systems

Report F--Principles and Guidelines for Foregoing Life-Sustaining Treatment in Adults, and Patient's Right to Refuse any Medical Treatment (Resolution 33, 1-86) (Constitution and Bylaws)

Report I--Mail Service Pharmacy (Resolution 91, 1-86)

Report W--Smokeless Tabacco

Report X--AIDS Risk Factors and Guidelines for the Health Care Setting

Report Y--Organ Procurement System

Report GG--Status Report on the Health Policy Agenda for the American People

Report II--AMA Initiative on Adolescent Health: Progress Report

Report RR--Report of the Special Task Force on Professional Liability and Insurance, and the Advisory Panel on Professional Liability

Report TT--Resident Physician Working Hours and Supervision

Reports of Council on Long Range Planning and Development

Report D--Physician Attitudes on Professional Autonomy, Medical Decision Making and Quality of Care

Reports of Council on Medical Services

Report B--Financing of Care for AIDS—The HIV Epidemic

Report I--MAACs: Current Status

Report K--Access to Care in Rural Areas

Reports of Council on Scientific Affairs

Report A--Firearms as a Public Health Problem in the United States: Injuries and Death

Report B--Cancer Risk of Pesticides in Agricultural Workers (Resolution 94, I-86)

Informational Reports:

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Merwin R. Blanden, MD
Tecumseh

Doctor Blanden, who had practiced medicine in Tecumseh for more than 40 years, died November 1 at the age of 78. Doctor Blanden received his medical degree from Ohio State University in 1939. He was a past president of the Lenawee County Medical Society and a member of the American Medical Association.

George (Frank) Newman, MD
Farmington Hills

Doctor Newman, a psychiatrist, died November 27 at the age of 66. He was born and raised in Alma. He attended the University of Michigan Medical School in the early 1940s before serving in the Army Air Corps during World War II. Doctor Newman taught anatomy at Emory University School of Medicine in Atlanta. He returned to Michigan for a residency in psychiatry at Northville State Hospital. In 1956, Doctor Newman established a private psychiatric practice in Dearborn and was a staff member at Oakwood Hospital. At the time of his death, he was a delegate to the American Psychiatric Society.

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FPR

Pain pathways page 63

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JULY 1987 VOL 9, NO 7

CLINICAL ARTICLES

● Endometrial Cancer: Causes and Patient Evaluation

■ Pain Management in Primary Care

Controlling Side Effects of Antipsychotic Drugs, Part 2: Extrapyramidal Symptoms

Osteoporosis, Part 2: Prevention and Treatment

KEEPING CURRENT

Assessing Impairment of Elderly Hospitalized Patients

Routine Radiological Testing for Respiratory Illness

Using Ultrasound to Detect Hip Abnormalities

Diagnosing Bone Infection Under Pressure Sores

Slowing Progression of Diabetic Nephropathy

Behavioral Disorders Among Children of Alcoholic Fathers

Catheter-Related Septic Central Venous Thrombosis

Withdrawing Patients From Antihypertensive Drug Therapy

Cesarean Section and Infant Survival

Preventing Neonatal Group B Streptococcal Disease

Diagnosing Acute Scrotal Pain

Urinary Tract Infections Among Uncircumcised Infants

Colonoscopy, Detecting Recurrent Colorectal Cancer

Surgical Management of Chronic Intestinal Ischemia

Preventing Travelers' Diarrhea

SPECIAL FEATURE

Willingway, A Fellowship in Alcoholism and Drug Addiction

DeKORNFELD/Continued

talents are largely devoted to the matter of issuing licenses. They are not involved in the wider aspects of the functions of the Board.

My title is Consultant to the Board of Medicine. My function is to serve the Board, to serve every single one of you and to establish a liaison between you and the Board. My office is in the Bureau of Health Services in Lansing and my telephone number is 517/335-1754.

I spend four days each week in Lansing, my address is c/o Michigan Board of Medicine, Box 30018, Lansing, Michigan 48909.

Please let me hear from you, please share your concerns with me, let me know how the Board could serve you better, let me know when you think that the Board has done a good job.

Do not, I repeat DO NOT, call the Board Office except on matters pertaining to specific licensing questions or with requests for applications.

New Year's Eve is over, but it is not too late to make another New Year's resolution. Resolve to contact the Board, to help the Board, to make suggestions to the Board and, once in a while, to pat the Board on the back. □

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Lloyd A. Bakken, MD — OBG
1840 Wealthy St., SE
Grand Rapids 49506

Inese Z. Beitins, MD — PD/PDE
D3252 Med. Professional Bldg.
Ann Arbor 48109

Danny S. Benjamin, MD — OBG
3225 Shadydale Ct.
West Bloomfield 48033

Saroj V. Bhat, MD — IM/NEP
24555 Haig
Taylor 48180

Ronald T. Burkman, MD — OBG
32533 Robinhood
Birmingham 48010

Richard P. Capriccioso, MD— EM
43050 Twelve Oaks Cir. C-301
Novi 48050

Manuel R. Chavarri, MD — IM/END
1501 W. Chisholm St.
Alpena 49707

Howard M. Comstock, MD — GS
124 Cole Rd.
Monroe 48161

Timothy J. Conroy, MD — PD
2666 Alpine, NW
Grand Rapids 49504

Alan A. D'Augustine, DO — AN
1335 Audubon
Grosse Pte. 48230

Paul C. Elsen, MD — FP
210 Lafayette, SE #303
Grand Rapids 49503

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1024 Professional Drive
Flint 48532

Ihn H. K. Han, MD — R
1225 Lincolnshire
Ann Arbor 48103

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3627 Bristol Dr.
Troy 48084

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5145 Aintree Rd.
Rochester 48064

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2224 Saginaw, SE
Grand Rapids 49506

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25901 E. Jefferson
St. Clair Shores 48081

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West Bloomfield 48233

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6767 W. Outer Dr.
Detroit 48235

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Muskegon 49442

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Grand Rapids 49505

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4201 St. Antoine
Detroit 48201

Shiu Man Lee, MD — IM
23733 Greening Ct.
Novi 48050

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Detroit 48201

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227 Riverside Ave.
Adrian 49221

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Sparrow Hosp. Path. Dept.
Lansing 48909

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818 Whitmore #210
Detroit 48203

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Bronson Medical Ctr. #216
Kalamazoo 49007

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24710 Walden Rd., W. #601
Southfield 48034

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32950 Five Mile Rd.
Livonia 48154

Edward J. Pearce, II, MD — IM/NEP
19930 Farmington Rd.
Livonia 48152

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West Bloomfield 48033

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8554 Canton Center Rd.
Canton 48187

Ruby C. Roc, MD — IM/END
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Canton 48187

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6572 Red Arrow Hwy.
Coloma 49038

Paul N. Rodriguez, MD — U
153 Lafayette, SE
Grand Rapids 49503

Stephen C. Ross, MD — IM
1634 Gull Rd. #101
Kalamazoo 49001

Continued on page 53

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category 1 programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category 1 credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

January

15, Basic Life Support for Health Professionals. Location: The Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Contact:** Jean Holther, Towsley Center for Continuing Medical Education, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 5 hours Category 1 Credit.

16-17, Advanced Cardiac Life Support Provider Course. Location: The Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Contact:** Jean Holther, Towsley Center for Continuing Medical Education, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 16 hours Category I Credit.

24, Coronary Artery Disease: Now and the Future. Location: Detroit Osteopathic Hospital, 8th Floor Auditorium, 12523 Third Avenue, Highland Park. **Contact:** Sue Klomparnes, Detroit Osteopathic Hospital Continuing Education, 12523 Third Avenue, Highland Park 48203 (313)252-4823. **Approved for:** 6 hours Category I Credit.

28, Annual Snow Meeting: OB/GYN Update. Location: Hidden Valley, Ostego Ski Club, Gaylord. **Sponsor:** Michigan Section, American College of Obstetricians and Gynecologists. **Contact:** John R. Musich, MD, Department of OB/GYN, William Beaumont Hospital, 3601 W. 13 Mile Road, Royal Oak 48072 (313)288-7224. **Approved for:** 8 hours Category I Credit.

31-2/5, The Twelfth Annual Midwinter Family Practice Update. Location: Boyne Highlands Inn, Harbor Springs. **Sponsor:** The University of Michigan Medical School, Department of Family Practice and The Michigan Academy of Family Physicians. **Contact:** Betty Phillips, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 20 hours Category I Credit.

February

4-6, The Eighth Annual Advances in the Management of Infectious Diseases: Update 1988. Location: Kahala Hilton, Honolulu, Hawaii. **Sponsor:** The University of Michigan Medical School, Ann Arbor. **Contact:** Karen McCalla, Office of Continuing Medical Education, The University of Michigan Medical School, G1100 Towsley Center, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 13 hours Category 1 Credit.

5-6, Advanced Trauma Life Support Provider Course. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School. **Contact:** Jean Holther, Office of Continuing Medical Education, The University of Michigan Medical School, Towsley Center—Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 18 hours Category I Credit.

7-12, Twelfth Annual Seminar on Emergencies in Medicine. Location: Boyne Highlands Ski Lodge, Harbor Springs. **Sponsor:** Michigan Committee on Trauma, American College of Surgeons. **Contact:** Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit 48201 (313)745-3484. **Approved for:** 25 hours Category I Credit.

16, The Medical Consequences of Nuclear War. Location: Clarion Conference Center, 6810 S. Cedar Street, Lansing. **Sponsor:** Ingham County Medical Society and MSMS Committee for Continuing Medical Education. **Contact:** Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)334-2320. **Approved for:** 6 hours Category I Credit.

19, Basic Life Support for Health Professionals. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School. **Contact:** Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 5 hours Category 1 Credit.

19-21, Advanced Cardiac Life Support Instructor Course. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School. **Contact:** Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 19 hours Category 1 Credit.

20, Advanced Cardiac Life Support Recertification. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School. **Contact:** Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 7 hours Category I Credit.

23-26, Microvascular Workshop for Otolaryngologists and Head and Neck Reconstructive Surgeons. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School. **Contact:** Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 30 hours Category I Credit.

March

10-15, Ophthalmology: Basic and Clinical Review Course. Location: Hotel Pontchartrain, 2 Washington Boulevard, Detroit. **Sponsor:** Kresge Eye Institute of Wayne State University School of Medicine. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, 4H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180. **Approved for:** 42 hours Category I Credit.

13-18, Emergencies in Medicine. Location: The Yarrow, A Dunfey Resort and Conference Center, Park City, Utah. **Sponsor:** Michigan Committee on Trauma, American

Continued on next page

CATEGORY I COURSES/ Continued

College of Surgeons. **Contact:** Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit 48201 (313)745-3484. **Approved for:** 25 hours Category 1 Credit.

15, **Patient Care for Practicing Physicians. Location:** Clarion Conference Center, 6810 S. Cedar Street, Lansing. **Sponsor:** Ingham County Medical Society and MSMS Committee for Continuing Medical Education. **Contact:** Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)334-2320. **Approved for:** 6 hours Category 1 Credit.

16-18, **A Symposium and Preceptorship in Diabetes Care. Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School. **Contact:** Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 19 hours Category 1 Credit.

20-25, **Facial Cutaneous Surgery: Mohs, Reconstructive, and Cosmetic. Location:** Copper Mountain Resort, Copper Mountain, Colorado. **Sponsor:** The University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 19 hours Category 1 Credit.

22-26, **Family Practice—1988 Twelfth Annual Spring Refresher and Board Examination Review. Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Family Practice and The Michigan Academy of Family Physicians. **Contact:** Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 33.75 hours Category 1 Credit.

23-24, **27th Annual Conference on Maternal and Perinatal Health: Issues in Primary Perinatal Practice. Location:** Amway Grand Plaza, Grand Rapids. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, Chief, Physician Education, Michigan State Medical Society, P.O.Box 950, East Lansing 48826-0950 (517)337-1351. **Approved for:** 13 hours Category 1 Credit.

April

8-9, **Advanced Trauma Life Support Instructor Course. Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School. **Contact:** Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 18 hours Category 1 Credit.

10-13, **Extracorporeal Membrane Oxygenation for Neonatal Respiratory Failure (ECMO) Basic and Advanced Courses. Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Departments of Surgery, Pediatrics and Communicable Diseases. **Contact:** Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 15 hours Category 1 Credit for the basic course and 7 hours Category 1 Credit for the advanced course.

13, **Educational and Health Perspectives of Dyslexia. Location:** Western Michigan University, Kalamazoo. **Sponsor:** Michigan Dyslexia Institute, Michigan Department of Public Health, Michigan Branch of the Orton Dyslexia Society, SLD Center of Kalamazoo. **Contact:** Alice Hamachek, Michigan Dyslexia Institute, P.O.Box 23025, Lansing 48901 (517)349-6522. **Approved for:** 5 hours Category 1 Credit.

14-15, **Annual Postgraduate Course in Obstetrics and Gynecology: Challenges and Changes of the 1980s. Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Betty Phillips, Office of Continuing Medical Education, The Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 15 hours Category 1 Credit.

16, **Emergency Medicine Oral Boards Preparation Course. Location:** St. Mary's Hospital, Saginaw. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians. **Contact:** Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500. **Approved for:** 5 hours Category 1 Credit.

19, **Is There a Difference Between the Practice of Medicine and the Practice of Osteopathy? Location:** Clarion Conference Center, 6810 S. Cedar Street, Lansing. **Sponsor:** Ingham County Medical Society and MSMS Committee for Continuing Medical Education. **Contact:** Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)334-2320. **Approved for:** 6 hours Category 1 Credit.

20, **Sleep Throughout the Life Cycle. Location:** Fetzer Center at Western Michigan University, Kalamazoo. **Sponsor:** Borgess Pulmonary Services. **Contact:** Judy Smith, Pulmonary Services, Borgess Medical Center, Kalamazoo (616)383-4875. **Approved for:** 6 hours Category 1 Credit.

28-29, **The Phlebotomy Team: Technical and Management Perspectives. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Pathology. **Contact:** Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 11 hours Category 1 Credit.

May

4-5, **Computed Tomography and Magnetic Resonance Imaging and Radiologic Technologist Program. Location:** The Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Radiology. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 22.5 hours Category 1 Credit.

5-7, **National Conference on Health Care Leadership and Management. Location:** Sheraton Harbor Island, San Diego, CA. **Sponsor:** The American Academy of Medical Directors. **Contact:** Sherry Mason, AAMD, 4830 W. Kennedy Blvd, Suite 648, Tampa, FL 33609-2517 (813)287-2000. **Approved for:** 16 hours Category 1 Credit.

MEETINGS

MICHIGAN STATE MEDICAL SOCIETY
1866

MSMS MEETINGS

January

20, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

March

2, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

23-24, 27th Annual Conference on Maternal and Perinatal Health: Issues in Primary Perinatal Practice, Amway Grand Hotel, Grand Rapids, contact: Sherry L. Fent, (517)337-1351.

April

29-5/1, MSMS House of Delegates Meeting, Hyatt Regency, Dearborn, contact: Richard Campau (517)337-1351.

September

14, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETINGS

February

12-14, Leadership Conference, Marriott Hotel, Chicago, contact: Carla Funk, AMA, 535 North Dearborn St., Chicago 60610 (312)645-4392.

June

26-30, AMA Annual Meeting, Chicago Hilton and Towers, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4392 (312) 645-4344.

MICHIGAN SPECIALTY SOCIETY MEETINGS

April

16, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500.

June

17-19, Annual Meeting—Michigan Association of Neurological Surgeons, Grand Traverse Resort, Traverse City, contact: William F. Chandler, MD, 1500 E. Medical Center Drive, Ann Arbor 48109 (313)936-5020.

July

21, Fifteenth Michigan Emergency Medicine Assembly—EMS Concepts 88 and Base Station Symposium, Michigan Chapter of the American College of Emergency Physicians, Hilton Shanty Creek, Bellaire, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500.

NATIONAL SPECIALTY SOCIETIES

February

16-21, Plastic Surgery Educational Symposia: The Fundamentals of Plastic Surgery—The Basics in Perspective, Snowbird, Utah, contact: Edward H. Withers, MD, Chairman, PSEF Clinical Symposia Committee, 233 North Michigan Avenue, Chicago, IL 50501 (312) 856-1818.

18-21, American College of Nuclear Physicians Annual scientific Meeting, Scottsdale Hilton, Scottsdale, AZ, contact: American College of Nuclear Physicians, 1101 Connecticut Avenue, N.W., Suite 700, Washington, DC 20036 (202)857-1135.

March

3-6, American College of Physicians Annual Meeting, New York, NY, contact: American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104 (215)243-1200.

Continued on next page

MEETINGS/Continued

20-23, American Society of Abdominal Surgeons Annual Scientific Meeting, Williamsburg Hospitality House, Williamsburg, VA, contact: American Society of Abdominal Surgeons, 675 Main Street, Melrose, MA 02176 (617)665-6102.

27-30, American College of Emergency Physicians Annual Meeting, Hotel Del Coronado, Coronado, CA, contact: American College of Emergency Physicians, P.O. Box 611911, Dallas, TX 75261-9911 (214)550-0911.

27-31, American College of Cardiology Scientific Meeting, Atlanta, GA, contact: American College of Cardiology, 9111 Old Georgetown Road, Bethesda, MD 20814 (301) 897-5400.

April

14-17, American College of Preventive Medicine Annual Scientific Meeting, Westin Peachtree Plaza, Atlanta, GA, contact: American College of Preventive Medicine, 1015 15th Street, N.W., Suite 403, Washington, DC 20005 (202)789-0003.

17-23, American Academy of Neurology Annual Meeting, Convention Center, Cincinnati, OH, contact: American Academy of Neurology, 2221 University Avenue, S.E., Suite 335, Minneapolis, MN 55414 (612)623-8115.

18-20, American Association for Thoracic Surgery Annual Scientific Meeting, Century Plaza, Los Angeles, CA, contact: American Association for Thoracic Surgery, 13 Elm Street, Manchester, MA 01944 (617) 927-8330.

23-29, American Occupational Medical Association Annual Meeting, New Orleans Marriott, New Orleans, LA, contact: American Occupational Medical Association, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312)228-6850.

24-28, American Association Neurological Surgeons Annual Meeting, Toronto, Ontario, contact: American Association Neurological Surgeons, 22 S. Washington, Suite 100, Park Ridge, IL 60068 (312) 692-9500.

29-30, American Academy of Facial Plastic and Reconstructive Surgery Interim Meeting, The Breakers, Palm Beach, FL, contact: American Academy of Facial Plastic and Reconstructive Surgery, 1101 Vermont Avenue, N.W., Suite 404, Washington, DC 20005 (202)842-4500.

May

1-4, American Association of Plastic Surgeons Annual Scientific Meeting, The Breakers, Palm Beach, FL, contact: American Association of Plastic Surgeons, University of Chicago, Box 269, 5841 S. Maryand Avenue, Chicago, IL 60637 (312) 962-6302.

1-5, American College of Obstetricians and Gynecologists Annual Scientific Meeting, Boston Sheraton, Boston, MA, contact: American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SW, Suite 300 East, Washington, DC 20024 (202)638-5577.

1-6, American Association of Pathologists Annual Scientific Meeting, Las Vegas, NV, contact: American Association of Pathologists, 9650 Rockville Pike, Bethesda, MD 20814 (301)530-7130.

2-4, Consensus Development Conference on Cochlear Implants, National Institute of Health, Bethesda, Maryland, contact: Michael J. Bernstein, Office of Medical Applications of Research, National Institutes of Health, Bethesda, Maryland 20892 (301)496-1143.

OTHER MEETINGS

February

22-26, Physician in Management-Seminar I, American Academy of Medical Directors, contact: Sherry Mason, American Academy of Medical Directors, 4830 W. Kennedy Boulevard, Suite 648, Tampa, FL 33609-2517 (813)287-2000.

April

6-7, Southeastern Michigan Medical Expo 88: Quality Medicine of the 90s, Wayne County Medical Society, contact: Wayne County Medical Society Service Bureau, Inc., 1010 Antietam Road, Detroit 48207 (313)567-1640.

25-26, Twelfth Annual Conference of the Michigan Association for Infant Mental Health, Ann Arbor, contact: Thomas Horner, PhD, Child and Adolescent Psychiatric Hospital, University of Michigan Medical Center, Ann Arbor 48109 (313)764-5304.

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MIDLAND, MICHIGAN Unique, urgent-care practice opportunity in a well-established center affiliated with local physicians and hospital. Prefer BC/BE in F.P. or E.M. Attractive salary and benefits. Located in professional, progressive, family-oriented community. Send inquiries and/or C.V. to Midland Physician's Med Center, c/o Rick Drimalla, MD or Margaret Wellman, Manager, 975 S. Saginaw Road, Midland, MI 48640.

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EMERGENCY ROOM OPENING Suburban Detroit hospital with established patient base has an immediate need for experienced emergency/family medicine physician, internist or general surgeon to staff emergency room/industrial/urgent care clinic with combined annual visits of 32K. Low trauma, low stress, flexible daytime scheduling with coverage, guaranteed hourly rate, and paid malpractice. Contact: Sandy Cundiff. Tyler & Company, 9040 Roswell Road, Atlanta, GA 30350, (404) 641-6411.

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INTERNIST, OB/GYN AND GENERAL PRACTICE PHYSICIANS Immediate opening in a busy established practice, located in the thumb of Michigan, about 100 miles from Detroit. Excellent schools, comfortable lifestyle with many opportunities for outdoor recreation. Competitive salary with all practice expenses paid, plus fringe benefits. Shareholder status available after first year. Reply to: Pigeon Clinic, PC, 7293 Michigan Avenue, Pigeon 48755 or call (517)453-3221.

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FAMILY PRACTITIONER or internist. Full or part time. Maybe semi-retired for physicians office in the Southfield, Lathrup area. Call Richard Corey, Administrator (313)557-5155.

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ORTHOPEDIC, OB/GYN, industrial and family practice doctors needed for a large multi-specialty group practice in suburban metro Detroit area. Excellent opportunity, all replies confidential. Please respond to Box 112, Michigan Medicine, 120 W. Saginaw, East Lansing, MI 48823.

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Continued on next page

CLASSIFIEDS/Continued

partnership in one year. Available July 1988, or earlier. Contact Matt Meyer, MD, Women's Health Care, S.C./Milwaukee Regional Fertility Center, 426 W. Main Street Waukesha, Wisconsin 53186, 414-549-1333.

FAMILY PRACTICE Newberry, Michigan—Helen Newberry Joy Hospital is looking for a family practice physician to replace an established physician. Will join 5 other doctors to provide care to a small northern Michigan town. 43-bed hospital serves surgical, OB and medical needs as well as a full range of outpatient services. Call collect. Contact Tom Hicks, Administrator, Helen Newberry Joy Hospital, Newberry, MI 49868 (906)293-5181.

INDIANA Prosperous residential community in northern Indiana is seeking a dermatologist. Twenty-tree physician group looking to add a second dermatologist to a rapidly growing practice. Excellent academic affiliation with the University of Notre Dame located nearby. Contact: Jean Ecos, 250 Regency Ct., Waukesha, WI 53186, (414)785-6500 (collect).

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GENERAL SURGEON Board-certified general surgeon needed to join expanding, 85-physician multi-specialty medical center in Los Angeles and Orange counties. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to Box 117, Michigan Medicine, P.O. Box 950, East Lansing, 48826-0950.

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MICHIGAN STATE UNIVERSITY is seeking a full-time board-certified gynecologist to supervise clinic in student health center. Excellent compensation and benefit package. Malpractice insurance provided. Inquiries: Dennis Jurczak, MD, 1-517-355-2488. Apply: Michigan State University Personnel Office, 1407 South Harrison Road, East Lansing, MI 48824. Refer to Category 071. MSU is an affirmative-action, equal-opportunity institution.

PHYSICIAN WANTED: Busy suburban Detroit medical center seeks qualified physician. Must be experienced in industrial medicine as well as family practice. Must hold current Michigan license. Call Margaret at (313)541-0433, or send CV to P.O. Box 12009, Birmingham, MI 48012.

MICHIGAN Emergency department directorships, full-time and part-time opportunities available throughout the state. Rural and urban locations. Guaranteed hourly rate and malpractice insurance provided. Benefit package available. Contact: Emergency Consultants, Inc., One Windemere Place, Room 23, Petoskey, MI 49770; 1-800-253-7092 or in Michigan 1-800-632-9650.

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Lab of Clinical Medicine	32
Lilly	10, 11, 16, 17
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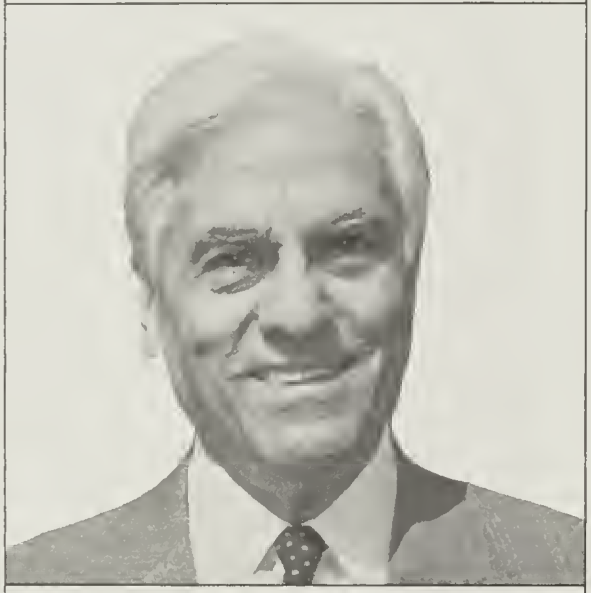
A just peace comes in stages



Carl A. Gagliardi, MD

At one of the darkest hours of the American Civil War, President Abraham Lincoln said "If we do not make common cause to save the good old ship of the Union on this voyage, nobody will have a chance to pilot her on another voyage."

The continuing medical liability crisis we physicians face here in Michigan has us in the throes of another type of civil war and the stakes are high. The casualties mount. Old friends move to friendlier states. Old patients are treated as potential lawsuits. Physician families gamble their livelihoods, homes and children's educations by going bare. People in need are denied access.

In the medical liability battle, we are pitted against an insidious enemy; ignorance. Ignorance on the part of the general public, ignorance on the part of the government, and yes, even some ignorance within our own ranks.

Ignorance is a harsh word and I use it here only in its definition as "lack of information."

To sound the clarion and inform the masses, we have taken to the streets to tell our story and make offers of peace.

We are visiting influential newspaper editorial boards asking for an unprecedented alliance with them. And we are getting it.

We are visiting with influential members of the legislature, again, asking for unprecedented cooperation. And we are getting it.

Doctor Gagliardi is 1987-88 MSMS president.

We are meeting with our own membership with unprecedented fervor, asking for unified support of our peace offerings. And once the facts are clear, we are getting it.

A just peace comes in stages. Our present peace plan is comprised of the following items.

First, pension protection. We expect a pension protection bill to get through the legislature in the first quarter of 1988.

Second, a governor-appointed task force to study alternatives to the tort system for settling claims of maloccurance and/or malpractice. We have reason to believe that such a task force will be appointed by mid-year. Recommendations made by the task force will likely take a year or two of legislative review, so to cover us in the interim, we are looking at our third item; Robben Fleming's proposed State Medical Liability Trust.

The Trust is complex. And not all of the details are available. But we are keeping an open mind right now until we have all of the facts. Specific wording for proposed legislation is being drafted now and will be ready for our inspection soon.

We are certain that the Trust is not the panacea for Michigan's medical liability crisis, but it might just hold our "good old ship" together over the next few years until we can develop a workable alternative to tort.

Since the Trust is so complex, and since not all details of the Trust are immediately available to us, we are polling the Board to determine if there is enough interest to call for a special session of the House of Delegates to put the Trust's draft legislation under the microscope once it is available.

In the meantime, our key phrase is "keep an open mind."

One definition of a president's job is that he or she must be "a leader, educator, wielder of power, pump; he (she) is also officeholder, caretaker, inheritor, consensus seeker, persuader, bottleneck. But he (she) is mostly a mediator."

Over the next few months I will play all of those roles and more; whatever it takes to pilot our ship safely for another voyage. ☐

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References: 1. Feighner JP, *et al* *Psychopharmacology 61* 217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc , Nutley, NJ

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Adverse Reactions: Most frequently reported are those associated with either component alone drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs

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Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract

Allergic. Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia

Gastrointestinal Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion

Other Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

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MICHIGAN MEDICINE

UARY 1988 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY VOL. 87, NO. 2

MSMS: Taking the lead in AIDS education

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MICHIGAN MEDICINE

February 1988 Vol. 87 No. 2

Special Report

MSMS is taking the lead to help you and your fellow health professionals cope with the AIDS epidemic. That's the message of this issue, from our cover through page 69. The individuals who are trained to teach the professionals are profiled here, as are the AMA policies regarding AIDS diagnosis, education and treatment upon which MSMS bases its own activities. MSMS president-elect Frederick W. Bryant, MD, who also serves as chairman of the MSMS Task Force on AIDS Provider Education, has a guest column on our president's page. Please read on to catch up on the latest AIDS education activities in your state. 58

Features

Legislative update
Both national and state legislation of interest to medicine are summarized here, through the assistance of the AMA and the MSMS Department of Government Relations 73

Quality care for physicians, families and staff
The new MSMS Group Health Insurance Benefit Program provides comprehensive, personal service — By Betty J. McNerney 80

Board of Medicine updates licensure rules
The Board of Medicine has taken some of the hassle out of physician licensing, particularly for graduates of foreign medical schools — By Thomas J. DeKornfeld, MD 84

Medical/legal fees
MSMS, the State Bar of Michigan and the Michigan Association of Osteopathic Physicians and Surgeons offer fee-setting guidelines for providing records, consultations and testimony 89

On the cover, from left to right, Daniel Havlichek, MD, East Lansing; Douglas A. Mack, MD, MPH, Grand Rapids, and Judene Bartley, MS, MPH, Royal Oak, leaders of AIDS provider education in Michigan.

Departments

In my opinion
The challenge of gatekeeping — Marguerite Shearer, MD 56
Letters 57
Physicians in the news 86
Deaths 100
Category I courses 102
Meetings 104
Classified advertising 107
Ad index 109
President's page
Education the rallying point in AIDS battle — Frederick W. Bryant, MD 110

In next month's issue of *Michigan Medicine:* Helping MSMS members through the Medicare maze.

Cover photo by Mike Schimpf.

IN MY OPINION

The challenge of "gatekeeping"

By Marguerite Shearer, MD

The ever-escalating costs of medical care are profoundly changing the requirements of medical decision-making. Ultimately, physicians will need to make a quantitative, in addition to a qualitative, judgement of whether a procedure may be of benefit to a patient. In other words we will need to include both medical and economic factors in our decision-making.

The basic functioning of the physician gatekeeper in a cost-containment setting is to keep as many patients as possible on the primary care, outpatient level. The role includes arranging for second opinions and deciding which tests are "cost-beneficial."

Doctor Shearer

Because the rationale for developing the gatekeeper system is one of financial efficiency, economic settings affect the mix of clinical and financial judgements and pose various ethical problems.

We can no longer deny the resource constraints that face us, and this development has potentially positive features. First, less use of hospitalization and other cost-intensive approaches should reduce patients' risk to iatrogenic illness. Secondly, it will behoove us to re-examine patterns of care — a surprising variation exists in physicians' use of standard medical and surgical treatments. These variations cannot be explained by objective evidence, consensual medical norms, or economic differences among patients.

What has been termed "practice-style factor" (subjective factors related to attitudes of individual physicians) apparently determines treatment patterns as much as do scientific norms. If gatekeeping experience is polled, a gradual physician consensus could result in the substitution of

Continued on page 99

Doctor Shearer is a member of the MSMS Board and of the MSMS Committee on Publications.

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Tuberculosis and AIDS

In 1986, the United States had its first increase in indigenous tuberculosis morbidity in at least 33 years. Tuberculosis morbidity in Michigan had also increased from 540 cases in 1985 to 615 cases in 1986. This increase in the state is taking place on a background of decreasing TB morbidity over the last half century. Current evidence clearly suggests that the increase is, at least in part, related to the AIDS epidemic.

Immunosuppression resulting from human immunodeficiency virus (HIV) infection appears to allow latent tuberculosis infection to progress to clinical disease.

This hypothesis that the recent TB increase both in the United States and Michigan may be partially attributable to the current AIDS epidemic is supported by findings from comparisons of AIDS and TB registries in many states. When compared in Michigan, about four percent of the cumulative AIDS cases also have or have had tuberculosis.

It was noted that tuberculosis often preceded AIDS and it is thus suspected that HIV infection, which has not progressed to clinical AIDS, may be sufficient to cause tuberculosis infection to progress to current tuberculosis disease.

Although *Mycobacterium avium* complex is the most common mycobacterial species isolated from patients with AIDS, disease caused by *M. Tuberculosis* is being recognized with increasing frequency.

The US Public Health Service and the American Thoracic Society recommend the following:

(1) Antituberculosis chemotherapy should be started whenever acid-fast bacilli are found in a specimen from a patient with AIDS or HIV infection. As a general rule, patients with TB and HIV infection respond to standard anti-TB drugs.

(2) Testing for HIV antibody should be performed in patients with tuberculosis disease or infection who are in one of the high-risk groups for HIV infection, or whose tuberculosis disease is disseminated or is characterized by severe or unusual manifestations.

(3) Persons who are HIV seropositive should be given a Mantoux skin test with PPD. Persons with clinical AIDS or HIV-related disease should also be given a tuberculin test. However, because they can be presumed to be immunosuppressed, they should receive a chest radiograph and be examined for evidence of extrapulmonary TB, regardless of the tuberculin skin test reaction.

(4) Because isoniazid has been shown to reduce the incidence of tuberculosis among a variety of populations with tuberculosis infection, any person who has a positive tuberculin skin test reaction and is HIV seropositive should be considered for isoniazid preventive therapy for 12 months, regardless of age.

Additional information may be obtained by contacting Ronald C. Burger of the TB Control Program of the Michigan Department of Public Health at (517) 335-8163.

Kenneth R. Wilcox, Jr., MD
Chief, Bureau of Laboratory and Epidemiological Services
Michigan Department of Public Health

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MSMS: Taking the lead on AIDS

By Mary Anne Ford
MSMS Chief, State Government Affairs

Strong leadership is necessary to respond to the AIDS epidemic. Thus MSMS has joined with state health officials, health professional associations and advocacy groups in "taking the lead" on AIDS. Through a unique contractual agreement with the Michigan Department of Public Health, MSMS has assumed responsibility for educating Michigan physicians, nurses, dentists and other health professionals about AIDS.

To educate Michigan physicians and other health professionals about AIDS, the health department asked MSMS to lead a task force for the purpose of identifying educational needs and strategies, and to develop means for implementing educational programs.

The AIDS Provider Education Task Force, which convened in October 1986, included representatives of 32 organizations representing virtually every type of health professional and health facility in Michigan. Implementation of the plan developed by the Task Force began in February 1987.

The MSMS and MDPH AIDS Education Project includes four basic elements.

First, a statewide AIDS Speakers Bureau has been established to address health professional groups throughout the state on various aspects of AIDS. Experts in infectious diseases, infection control, psychology, social work and medical ethics have addressed over 5,000 health professionals since the AIDS Speakers Bureau began in March 1987.

An AIDS Telephone Information Network provides quick access to information about AIDS for professionals throughout the state. Questions about infection control, testing, and support services can be answered through the use of a toll-free number. The AIDS Telephone Information Network is housed at the Wayne County Medical Society. Many of the experts on the AIDS Speakers Bureau also provide their services to return calls for the Telephone Information Network. Wayne County Medical Society staff have information on hand about testing sites and local support services and can mail information on infection control upon request.

> **"Through a unique contract with the Michigan Department of Public Health, MSMS has assumed responsibility for educating Michigan physicians, nurses, dentists and other health professionals about AIDS."**

The AIDS Telephone Information Network is open for calls from health professionals Monday through Friday, from 9:00 a.m. to 2:00 p.m. In Detroit, the number is 567-0399; outside Detroit it can be reached toll-free by calling 1-800-522-0399.

Responding to concerns about protection of health care workers and infection control is the third element of professional education activities. Infection control guidelines developed by a committee of experts have been broadly disseminated. A January 20 conference for hospital administrators and infection control directors provided information on planning for the implementation of universal infection control precautions within Michigan's hospitals.

Finally, special training programs are being funded to offer in-depth information to specific professional groups. Through this initiative, health professional associations can develop training programs which meet the unique needs and concerns of their profession.

MSMS efforts are not limited to those funded by the state for professional education. Members of the MSMS Auxiliary have been active in sponsoring educational forums on AIDS in Kent, Ingham and Saginaw Counties. Regular MSMS meetings, including the Annual Scientific Meeting, the Maternal and Perinatal Health Conference and the Public Affairs Leadership Conference, have featured sessions on AIDS. "AIDS Update," an informational brochure for the public produced by MSMS, has been widely distributed.

MSMS also has been active in discussions on AIDS policy. Active participation by MSMS members on a variety of state-level task forces and committees on AIDS has been critical to assuring physician input into state policy.

AIDS legislation has been carefully reviewed and monitored by the MSMS Committee on State Legislation and Regulations, with the goal of incorporating AMA recommendations into Michigan policy. MSMS supported the recently passed Michigan Health Initiative, assuring substantial funding for AIDS education and treatment in the future.

A subcommittee of the MSMS/State Bar of Michigan Interprofessional Liaison Committee currently is studying critical medical/legal issues surrounding the AIDS epidemic to provide guidance to the state and to individual physicians and attorneys in dealing with sensitive legal concerns.

MSMS is proud of its accomplishments and efforts regarding AIDS. It is important to acknowledge as well the efforts of individuals in taking the lead on AIDS. MSMS President-elect Frederick W. Bryant, MD, has devoted much of his time in the past two years to coordinating our efforts. So too have the five individuals profiled in this Special Report and the thousands like them throughout Michigan and the nation who are "taking the lead" on AIDS.

Interviews shed light on AIDS

Editors' note: *Michigan Medicine* recently interviewed four Michigan physicians and one nurse — all of whom are directly or indirectly involved in treating people who have AIDS. Throughout the interviews, these five individuals expressed their dedication to the treatment, prevention and cure of AIDS.

Bartley

Judene Bartley, MS, MPH, CIC
Department of Epidemiology
Harper Hospital
Detroit

Q: With currently over 400 AIDS cases diagnosed statewide, 3,000 cases predicted by 1991, and between 15,000 and 40,000 individuals infected now, do you think the health care system is prepared to handle the AIDS crisis?
A: No, clearly, at this point, Michigan's system is not prepared to handle the number of potential AIDS cases. However, Michigan has been learning from the experiences of other states like New York and California to develop resources before the current system becomes overwhelmed.

Q: Do you feel that health care workers' fears about caring for AIDS patients are a major concern in hospitals, and if so, what can be done to assuage these fears?
A: Fear about care for patients with AIDS can be a major concern. Our immediate weapon is education and we have to make it as effective as possible in its broadest sense, considering both informational and emotional aspects.

Do you see the responsibility of caring for AIDS patients as a deterrent to individuals entering the health care field?
A: That is as difficult to answer

Continued on next page

as it is to know the motivation for entering the profession of choice. I think the key for the future will be the attitude picked up by members already in the profession. It is clear that negative attitudes expressed by respected physicians have a powerful affect on other health care workers who may already be tentative about their feelings in caring for AIDS patients.

Q: What do you see as your mission?
A: Primarily to continue in my specific role as educator, among many educators, to effect the kind of changes in attitudes and practices that it will take to respond to the AIDS crisis now and in the future. We have a unique opportunity in Michigan to really make the system work for us. It is encouraging to know that various coalitions are trying to gain public and private monies to educate, develop and provide health care systems and ways to pay for it in the future. I feel a sense of commitment to do whatever can be done through our various organizations working together to promote these efforts for everyone's future.

Q: If there was a message you could send to physicians and health care workers around the state who are working with AIDS patients or may do so in the future, what would that message be?
A: That we cannot wait until each person has been touched personally in some way through a family member or friend before confronting the fears we all have.

My particular area of interest is development of a safe approach to all patients in the health care facilities/physician offices. Current infection control programs play “catch up“—educating staff on preventive behavior after the diagnosis, likely after an unwitting exposure. My hope is that most facilities and clinics will begin to switch gears and approach all patients with the same preventive, protective and caring behavior.

Crane

Lawrence R. Crane, MD
Division of Infectious Diseases
Wayne State University

Q: Do you feel that health care workers' fears about caring for AIDS patients are a major concern in hospitals?
A: Yes, it is a major concern. You can talk about policies all you like, but the first AIDS patient comes in and it all flies out the window. Preparation is critical and ongoing programs are necessary to address those working concerns — and the social and societal concerns as well. I think virtually every hospital will need to address this at some point.

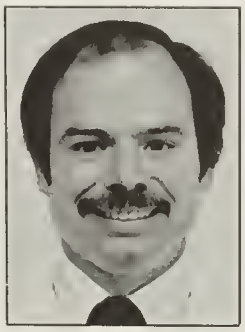
Q: How has working with AIDS patients affected you?
A: In some ways, AIDS has allowed me to do what I was trained to do — heal and provide physical and spiritual comfort. I think of the turn of the century painting of the physician, and realize my work with AIDS patients has brought me back to some of the more traditional values of the medical profession.

Q: What is your message to other physicians concerning AIDS?
A: Learn about it! All of us are going to be touched by AIDS, personally and professionally. Every primary care practitioner will be faced with the epidemic in practice, and everyone must learn how to care for their patients who are confronted with AIDS and with the public questions about AIDS. All of us will need help in dealing with it.

Hugh Gunner Deery II, MD
Hospital Epidemiologist
Northern Michigan Hospitals
Petoskey

Q: Do you feel the health care system is prepared to handle the AIDS crisis?
A: In terms of the health care system, I think, economically, we are not prepared to handle the crisis; but in terms of what we have in place, our medical technology, our ability to handle the complications, I think we are prepared.

The major problem I'm seeing is providing the resources of time to help patients with AIDS and AIDS Related Complex (ARC) deal with their illness as it affects them in their relationships and interactions with family, friends and fellow employees. This is a major part of the problem that is not talked about too much, but on a practical level, seems to be the foremost problem facing the patients I have.


Deery

Q: What do you see as your mission in caring for AIDS patients?
A: My major mission is the prevention, control and treatment of infectious diseases. That goes from A to Z—“A“ being AIDS, and “Z“ being Zuppa Fever; it's all the same.

Q: What is your message to fellow physicians?
A: I am personally an optimist. I believe the basic research that the AIDS crisis is generating will open doors to a better understanding of the pathogenesis of other diseases, including cancer. I think that we will eventually overcome the AIDS virus. But, in the meantime, we need to remain objective and professional in dealing with AIDS and the AIDS-related issues.

Daniel Havlichek, MD
Dept. of Infectious Diseases
Michigan State University

Q: Do you feel the health care system is prepared to handle the AIDS crisis?
A: I generally don't believe it is. There's going to have to be an emphasis on out-patient therapy, certainly, and there's going to have to be provisions made for in-home care of patients. Work with experimental medications and probably some costly follow-up of people while they're on these experimental medications will also be needed.

Q: What do you see as your mission in the role you have right now as a consultant? What do you hope to accomplish?
A: I really think preventing people from getting HIV infection is number one. I tend to support and do things that I think will prevent people from coming down with HIV infection. I believe that the majority of individuals infected are eventually going to have problems. At this point in time, I'm not convinced that the treatments we have for this are, in the long run, going to be too beneficial. My primary goal is to try to prevent any spread of AIDS from here on out and to help the people who have AIDS the best way I can.

Havlichek

Q: Do you agree with the AMA's statement that physicians have an ethical and moral responsibility to treat AIDS patients?
A: I do. That's just the way I basically feel and practice. That's one of the reasons why I chose this profession. I guess physicians have the right to refuse to take care of anybody they want to, but I don't think it's the ethical thing to do.

Continued on next page

INTERVIEWS/Continued

Douglas A. Mack, MD, MPH
Public Health Director
Chief Medical Examiner
Kent County

Q: Do you think the health care system is prepared to handle the AIDS crisis? If not, what needs to be done?

A: From a public health perspective, I look on the AIDS problem as not really being limited to the health care system. I would look for community response to handle the crisis and have done so in Kent County.

Mack

It was a year ago that I approached one of our upstanding community groups made up of about 40 private individuals and said that it was time now for the community to look at the AIDS issue. Much to my surprise, the group endorsed the idea. Out of that effort we developed a three-organizational unit-type plan: (1) the AIDS Foundation, an independent, free-standing, private, non-profit organization whose primary purpose would be to solicit funds, with the intent of those funds being applied toward the AIDS issue; (2) the AIDS Council, made up of a cross-section of many disciplines and organizations within the community, whose purpose would be to look at all the issues related to AIDS and to determine what might be considered unaddressed needs within the community; and (3) a grass-roots group made up of all the provider organizations within the community that currently were actively involved in the AIDS issue, such as Hospice. That group would then collectively be the resource for the Council. At present, we're still in the process of organizing these three units.

AMA report offers guidance

Editor's note: At its June, 1987 House of Delegates, the American Medical Association adopted 17 recommendations on issues pertaining to AIDS testing, prevention, research and resources. Several of the issues addressed in the AMA report are relevant to policy discussion currently underway in the Michigan legislature and health department. Excerpts from Report YY of the AMA Board of Trustees follow. Copies of the complete report may be obtained from MSMS.

I. Voluntary and Mandatory Testing

Knowledge that a person is infected with the AIDS virus can be the crucial predicate to changing behavior. Thus, testing for an antibody to the AIDS virus, when used in conjunction with appropriate counseling (and when offered in the context of appropriate anti-discrimination and confidentiality protections as discussed below), serves the important public health purpose of providing impetus for behavior changes that minimize the risk of transmitting the AIDS virus. Clearly, the need for HIV-antibody testing must center on the following justifications:

1. To identify infected persons and to offer treatment where possible and to protect uninfected third parties.
2. To offer education and counseling that would modify high risk behavior.
3. To solicit patient cooperation for locating and referring sex partners.
4. To obtain broadened epidemiological statistics on the prevalence of HIV infection in the population.

Except for individuals in the limited categories listed in the recommendations below (blood, organ and semen donors, immigrants, military personnel, prison inmates) with regard to whom testing serves well-established and well-accepted protection goals, mandatory national testing should not, at present, be broadly extended.

Military personnel have traditionally been subject to mandatory immunizations and our defense forces, of course, must be as strong as possible. Prison inmates, because they are confined and have a higher incidence of high-risk individuals than the general population, require special protection. Immigrants should be tested so that we can focus on the AIDS problem already here, and the nation certainly has the right to bar entrants with communicable diseases. The need to test donors of blood, organs and semen has never been questioned.

Public health authorities have advanced a plausible premise for their opposition to mandatory testing of homosexuals and drug abusers: such testing will only drive people underground and away from the health care system. Public health authorities also have advanced a premise for not requiring mandatory testing of large segments of the general population, such as all those seeking marriage licenses or all those admitted to hospitals. Such testing in low prevalence populations would result in a high proportion of false positives, and would not be cost effective, given the demand for voluntary testing and the shortage of testing and counseling resources for those who want them voluntarily or who will want them following effective public awareness campaigns.

"Public health authorities have advanced a plausible premise for their opposition to mandatory testing of homosexuals and drug abusers: such testing will only drive people underground and away from the health care system."

Until those premises are shown by superior studies to be incorrect, a policy regarding mandatory testing which has been rejected by the vast majority of public health officials, including the Centers for Disease Control and the Surgeon General, cannot be recommended.

But certain high risk groups should be regularly tested, with a right to informed consent and to refuse the test. Those groups are defined in the recommendations.

In addition, physicians and other hospital personnel involved in invasive surgical procedures who necessarily and unavoidably come in contact with the blood of patients, need to be aware of their risks. Limited regular testing of patients will assure that the CDC guidelines for the protection of hospital personnel are followed rigorously and will further assure that all patients receive prompt and full treatment. Physicians have a long and honored tradition of tending to patients afflicted with infectious diseases with compassion and courage. That tradition must and will be continued throughout the AIDS epidemic.

Because the risk to health care personnel will be slight in most areas, any effort at mandatory testing of certain kinds of patients should be instituted after voluntary testing has failed and where a variety of factors (e.g. the costs and availability of proper testing and counseling as measured against the risk presented by the relative presence of a high risk patient population), weigh in favor of mandatory testing.

The AMA does not believe it appropriate at this time to extend regularly offered testing to persons other than those listed, e.g., recommended testing should not be extended to all individuals anywhere who are considering marriage or to all persons in hospitals. Decisions about whether there should be generally recommended testing to other types of individuals should, at this time, be left to the decision of the local

Continued on next page

AMA/Continued

community depending on its own circumstances and the judgments of its own public health officials.

At present, each case of AIDS must be reported by the individual physician to state public health authorities either by name or identifier. Anonymous, or if carefully implemented, confidential reporting should also be extended to all confirmed instances of persons infected with AIDS virus but not afflicted with ARC or AIDS. Individuals who are seropositive for the HIV antibody are infected with the virus and can spread the disease as certainly as those with symptoms of AIDS. A sound epidemiologic understanding of the potential impacts of AIDS on society requires the reporting of those who are confirmed as testing positive for the antibody to the AIDS virus.

- Physicians should counsel patients before tests for AIDS to educate them about effective behaviors to avoid the risk for AIDS for themselves and others. In public screening programs, counseling may be done in whatever form is appropriate given the resources and personnel available as long as effective counseling is provided.
- Physicians should counsel their patients who are found to be seropostive regarding (a) responsible behavior to prevent the spread of the disease, (b) strategies for health protection with a compromised immune system, and (c) the necessity of alerting sexual contacts, past and present, regarding their possible infection by the AIDS virus. Long-term emotional support should be provided or arranged for seropositive individuals.
- Patients should knowingly and willingly give consent before a voluntary test is conducted.

II. Protection against discrimination

The AMA believes strongly that AIDS victims and those who test positively for the antibody to the AIDS virus should not be treated unfairly or suffer from arbitrary or irrational discrimination in their daily lives.

A sound anti-discrimination approach does not allow reflexive discrimination against AIDS victims based on fear or stereotype or prejudice. Nor does it require that all employers or other federal fund recipients automatically accommodate a person afflicted with a communicable disease. Instead, based on an individualized analysis of the nature and duration of the handicap and the nature and duration of the communicability, a federal fund recipient must make a reasonable accommodation based on reasonable medical judgments, given the state of medical knowledge at the time. This sound framework for carefully balancing the two competing concerns—the right of the victim to be free from irrational acts of prejudice and the right of others to be protected against an unreasonable risk from disease—should also guide state antidiscrimination efforts.

In order to encourage people to seek counseling, and testing if necessary, the AMA strongly urges that anti-discrimination laws at both the federal and state levels be clarified either by regulatory interpretation or statutory amendment to cover those who test HIV antibody positive.

The ability of the health care community to maintain the confidentiality of patient information and restrict its use to only those purposes essential for maintenance of health is, like clarification of antidiscrimination laws, vital to an effective program of preventing and controlling AIDS. Even if anti-discrimination laws were completely effective, which unfortunately is not likely, persons who test positive will suffer stigma. Thus, confidentiality is crucial.

The basic principle should be that access to patient information should be limited to health care personnel who have a legitimate need to have access to the information in order to assist the patient or to protect the health of others closely associated with the patient.

Anti-discrimination and confidentiality recommendations

- Anti-discrimination laws must be clarified or amended to cover those who test positive for the antibodies to the AIDS virus.
- Model confidentiality laws must be drafted which can be adopted at all levels of govern-

ment to encourage as much uniformity as possible in protecting the identity of AIDS patients and carriers, except where the public health requires otherwise.

III. Questions for the future

As the national debate on prevention and control of AIDS continues, other important issues will need to be addressed.

One of the more difficult issues for society is how to warn unsuspecting spouses or sexual partners of persons who test HIV positive. Such a warning would allow the third party to practice "safer" sex or to abstain from sexual relations with the infected person altogether. Given the life-or-death consequences, the unsuspecting third party should, as a general matter, be warned because there is no cure and because it may not be responsible to rely solely on the infected person to provide a suitable warning.

Testing recommendations

- Tests for the AIDS virus should be readily available to all who wish to be tested. The tests should be routinely subsidized for individuals who cannot afford to pay the cost of their test.
- Testing for the AIDS virus should be mandatory for donors of blood and blood fractions, organs and other tissues intended for transplantation in the U.S. or abroad, for donors of semen or ova collected for artificial insemination or invitro fertilization, for immigrants to the United States, for inmates in federal and state prisons and for military personnel.
- Voluntary testing should be regularly provided for the following types of individuals who give an informed consent:

1. Patients at sexually transmitted disease clinics.
2. Patients at drug abuse clinics.
3. Pregnant women in high risk areas in the first trimester of pregnancy.
4. Individuals who are from areas with a high incidence of AIDS or who engage in high risk behavior seeking family planning services.
5. Patients who are from areas with a high incidence of AIDS or who engage in high risk behavior requiring surgical or other invasive procedures. If the voluntary policy is not sufficiently accepted, the hospital and medical staff should consider a mandatory program for the institution.

- As a matter of medical judgment, physicians should encourage voluntary HIV testing for individuals whose history or clinical status warrant this measure.
- Individuals who are found to be seropositive for the AIDS virus should be reported to appropriate public health officials on an anonymous or confidential basis with enough information to be epidemiologically significant.

Physicians who have reason to believe that there is an unsuspecting sexual partner of an infected individual should be encouraged to inform public health authorities. The duty to warn the unsuspecting sexual partner should then reside in the public health authorities as well as the infected person and not in the physician to the infected person.

The AMA believes that mechanisms, analogous to those used by public health authorities to warn sexual partners about other sexually transmitted diseases, should be put in place to warn unsuspecting third parties about an infected sexual partner. Such warning may be appropriate whether the infected person is bisexual, heterosexual or homosexual.

This problem raises the general question of whether anonymous reporting should continue to be the standard for persons who test seropositive. Our recommendation at this time is limited to situations where physicians or health officials already know the identity of the AIDS carrier and have reason to believe a risk to third parties exists.

A related question which must be explored is whether an infected person, who knows he or she is infected and who knowingly fails to warn a sexual partner of the infection, should be subject not just to tort suits, but to a proceeding brought by state authorities to sanction the individual.

ANNOUNCING

NEW

KEFTAB™

cephalexin hydrochloride monohydrate

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eftab is contraindicated in patients with known allergy to the ephalosporins and should be given cautiously to penicillin-ensitive patients.

enicillin is the drug of choice in the treatment and prevention f streptococcal infections, including the prophylaxis f rheumatic fever.

---

ue to susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.
ue to susceptible strains of *Escherichia coli*, *Proteus mirabilis*, and *Klebsiella* sp.
ue to susceptible strains of group A β-hemolytic streptococci.

KEFTAB™
(cephalexin hydrochloride monohydrate)

Summary: Consult the package literature for prescribing information.

Indications and Usage:

Respiratory tract infections caused by susceptible strains of *Streptococcus pneumoniae* and group A β-hemolytic streptococci.

Skin and skin structure infections caused by susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.

Bone infections caused by susceptible strains of *S aureus* and/or *Proteus mirabilis*.

Genitourinary tract infections, including acute prostatitis, caused by susceptible strains of *Escherichia coli*, *P mirabilis*, and *Klebsiella* sp.

Contraindication: Known allergy to cephalosporins.

Warnings: KEFTAB SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Keftab in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Keftab should be administered cautiously in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy and lactation. Cephalexin is excreted in mother's milk. Exercise caution in prescribing Keftab for these patients.
- Safety and effectiveness in children have not been established.

Adverse Reactions:

- *Gastrointestinal*, including diarrhea and, rarely, nausea and vomiting. Transient hepatitis and cholestatic jaundice have been reported rarely.
- *Hypersensitivity* in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis.
- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruritus, genital moniliasis, vaginitis/vaginal discharge, dizziness, fatigue, headache, eosinophilia, neutropenia, and thrombocytopenia; reversible interstitial nephritis has been reported rarely.
- Cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment.
- *Abnormalities in laboratory test results* included slight elevations in aspartate aminotransferase (AST, SGOT) and alanine aminotransferase (ALT, SGPT). False-positive reactions for glucose in the urine may occur with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

PV 2060 DPP [091887] 849336

AIDS Speakers Bureau active

Approximately 70 physicians and other interested persons attended the MSMS AIDS Speakers Bureau update session in mid-November in Ann Arbor. The session was to help prepare speakers bureau members to provide information to other groups. Among the participants were Reynard Bouknight, MD, left, and Mary Noth, RN.

Judene Bartley, MS, speaker, discussed CDC guidelines for universal precautions, such as gloving issues, disinfection and the surveillance/epidemiology. The speakers bureau members have spoken to 165 groups around the state.

Another participant was Daniel Havlichek, MD, right. Topics of the session included legal and ethical issues, the Centers for Disease Control guidelines, Michigan Department of Public Health policies, and the continuum of care of AIDS patients.

If you would like to arrange for a trained speaker on AIDS to address your group, contact Rose Heald at MSMS headquarters, 517/337-1351.

Bureau receives letters of praise

Editor's note: MSMS has received several letters praising the AIDS Speakers Bureau. The following are a few of the dozens of letters MSMS has received.

"Thank you for your excellent organization of the AIDS Seminar held here on October 21, 1987. We could not have presented a program that was enjoyed by so many people without your help.

"Each presentation was well-received by members of the staff present. We have heard many favorable comments from attending participants.

"Your help in furthering our Continuing Medical Education Program is greatly appreciated. We look forward to working with you again in the future."

Krishna K. Sawhney, MD,
Director—Continuing Medical Education,
Heritage Hospital
Taylor

"On October 16th last we had the privilege of spending time with a most eloquent and knowledgeable Seminar leader, namely, Dale Ross.

Continued on next page

Speakers Bureau participants

Susan Adkins, RN
East Lansing
Laura Ashton, RN
St. Clair Shores
Jeffrey Band, MD
Royal Oak
Judene Bartley, MS, MPH
Oak Park
Donald H. Batts, MD
Kalamazoo
Lorraine Beers, RN
Traverse City
Pauline M. Bergeron, RN
Trenton
Michele Lynn Bielski, RN
Sterling Heights
Gerald W. Blackburn, DO
Farmington Hills
Julie Blom, MSW
Birmingham
Reynard R. Bouknight, MD, PhD
Okemos
Howard Brody, MD, PhD
East Lansing
Frederick W. Bryant, MD
Royal Oak
Timothy Burke, MD
Traverse City
Julie Chamberlain
Grand Rapids
P.H. Chandrasekar, MD
Grosse Pointe Park
Scotty Connolly, RN
Alto
Loredana Cooper
Mt. Clemens
Lawrence R. Crane, MD
Detroit
David S. Davenport, MD
Kalamazoo
Kay Davidson, RN
Kalamazoo
Hugh Gunner Deery II, MD
Petoskey
John Dyke, PhD
Ionia
Beth Dziekan, RN
Detroit
James Fahner, MD
Ann Arbor
Wiley Fan, DO
Farmington Hills
Robert Fekety, MD
Ann Arbor
Elaine Flanagan, RN
Livonia
Leonard Fleck, PhD
East Lansing
Mary Lou Gillard, RN
Rochester
Pamela Goran
Flint
Frank Henry Gowaty, MD
Gadsden, Alabama
Peter Gulick, DO
Okemos
Erwin Haas, MD
Grand Rapids
Daniel Havlichek, MD
Lansing
Carol E. Hayes
Lansing
Elizabeth Horan, RN, MSN, CIC
Wixom
Kenneth Howe, PhD
Boulder, Colo.
Suellen Hozman
Lansing
Billie Johnson, RN
Jackson
Jill Joseph, PhD
Ann Arbor
John Kateley, PhD
Okemos
Carol A. Kauffman, MD
Ann Arbor

Continued on next page

LETTERS/Continued

"You will have seen the evaluations collected at the closure of the day, and, from the results shown, must know how appreciative his audience was.

"This in itself would have made for a satisfying day, but the lily was gilded when I informed my colleagues that your Society had been generous enough and sufficiently concerned for humans in distress, to ignore that invisible international boundary that, so often, creates a barrier to understanding and communication."

Edwin C. Clarke
President & Chief Executive Officer
The Family Service Bureau of Windsor & Essex County
Windsor, Ontario

"On behalf of the Department of Family Medicine, I want to thank you and the AIDS Education Project of the Michigan State Medical Society for your support of the seminar on AIDS which our department sponsored. We believe that our adjunct clinical faculty have a clearer picture of the diagnosis and management of the AIDS patient by the family practitioner as a result of the seminar.

"A total of 55 physicians attended the seminar. The evaluations were quite positive and appreciative, praising the excellent speakers and the timely topic."

Margot E. Kurtz, PhD
Michigan State University
East Lansing

SPEAKERS BUREAU/Continued

Joan Kirkwood, RN
Grand Rapids
Nicholas J. Lekas, MD
Dearborn
Donald P. Levine, MD
Detroit
Edward B. Lewin, MD
Birmingham
Emigh Litch, RN
Detroit
Tom Madhavan, MD
Bloomfield Hills
Arnold Markowitz, MD
Keego Harbor
Norman Markowitz, MD
Detroit
David B. Martin, MD
Traverse City
Elizabeth McGough
Detroit
Michael McIlroy, MD
Detroit
Eve Mokotoff, MPH
Detroit
John A. Molinari, PhD
Detroit
Catherine Moore, RN
Grand Rapids
Willys F. Mueller, MD
Fenton
Dennis L. Murray, MD
Williamston
Marc Nienhuis, PharmD
Bay City
Mary Noth, RN
Warren
Susan Oleszkowicz, MPH
Dearborn
Russell Olmsted, MPH
Ann Arbor
David G. Ostrow, MD, PhD
Ann Arbor
Kathleen Petersen, MS
Livonia
Madelyne Plotkin
Detroit
Randall Pope
Lansing
Abby Rosenthal
Detroit
Dale G. Ross, MSW
Southfield
Nathaniel Rowe, DDS, MS
Ann Arbor
Bernard M. Sabatini, CDT
Hazel Park
Louis Saravolatz, MD
Ypsilanti
Alexandra Sauber, RN
Grosse Pointe Park
Glenda Shell, RN
Rochester Hills
Ronald J. Sherman, DO
Rochester
Dale Ann Singer, MD
East Lansing
Jack D. Sobel, MD
West Bloomfield
Jeff Stewart, DDS
Ann Arbor
Maxine Thome, MSW, MPH, PhD
Lansing
Thomas Tomlinson, PhD
East Lansing
Richard M. Tooker, MD, MPH
Kalamazoo
Ronald Walker, JD
Detroit
Karal Wasserman, MSW
Ann Arbor
Allen Weathers, AEMT
Warren
Susan Williams, RN
Flint
Lynn Marie Zimmerman, RN
Grand Rapids

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:
Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L73B Date of issuance Apr. 1987

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Legislative update

Editor's note: To help keep MSMS members up to date on legislative developments which affect the medical profession, key bills, passed or pending, are highlighted below.

Federal

Clearinghouse

Concerted AMA lobbying on both the federal and congressional fronts achieved a major victory with House and Senate passage of S.1158. This bill includes provisions absolutely essential to physicians. It would effectively amend the Health Care Quality Improvement Act of 1986 to eliminate broad access by malpractice attorneys to physician data bank information. The bill now goes for signature to President Reagan who opposed the bill by waging a final all-out attempt to defeat the measure.

Drug dispensing

The strength of AMA contacts both in Washington and from the Federation has kept the Wyden prescription drug dispensing bill from reaching the House floor. The bill now appears dead for the remainder of this congressional session.

Tobacco

Building on AMA focus on the ill-health consequences of tobacco smoking, both the House and Senate are in conference on a bill that would ban smoking on most domestic airline flights. AMA continues to keep up the pressure on this key health issue and appears headed for a major "win."

Professional liability insurance

AMA-sponsored bills to resolve the medical malpractice insurance crisis continue to serve as the focal point for congressional debate. In discussions with the major congressional players in this area, AMA input and support is viewed as critical to moving the legislation. AMA will continue seeking a workable federal solution in this area through its leadership role.

Catastrophic Medicare coverage

Both the House and Senate have passed bills to protect the nation's elderly from catastrophic medical expenses. Through persistent AMA efforts the Senate version explicitly prohibits a drug formulary. AMA will redouble its efforts with House and Senate conferees to ensure that no formulary or similar provision is added.

UBIT

Although the House-passed reconciliation bill contains a provision that would tax the investment income of 501(c)(6) professional and trade associations, AMA continues its efforts to keep the provision from becoming law. In a recent letter to Senate Finance Committee Chairman Bentsen, over 20 senators joined in opposing the provision. With the help of the Federation, we hope to stop the UBIT provision from being enacted into law.

Campaign financing

S.2 and its subsequent progeny, which would have mandated taxpayer financed congressional elections, have been swept from the congressional scene. Congratulations rest with AMA and Federation lobbying in derailing this ill-conceived scheme.

PROs

Thanks in large measure to the unyielding demands of the AMA, the House and the Senate Finance Committee passed reconciliation bills containing language essential to physicians involved in peer review. Chief among the victories on this front was significant added due process protection for physicians. AMA will continue the fight to retain these provisions in the budget summit reconciliation process.

State

HB 4176, sponsored by Rep. Perry Bullard, (D-Ann Arbor) would allow for the execution of a determination of directing certain medical procedures to be

Continued on next page

UPDATE/Continued

provided, withdrawn or withheld. HB 4176 is currently on the House floor.

HB 4463, sponsored by Rep. Lloyd F. Weeks, (D-Warren) would expand the chiropractic scope of practice to include physical examinations and the use of ancillary physical measures and diagnostic instruments. HB 4463 has passed the House and is in the Senate Committee on Commerce and Technology.

SB 261, sponsored by Sen. Dan L. Degrow, (R-Port Huron) and **HB 4666**, sponsored by Rep. Michael J. Griffin, (D-Jackson) would protect pension plan assets from bankruptcy proceedings following a civil judgment. Both bills are in the House Judiciary Committee.

SB 481, sponsored by Sen. Lana Pollack, (D-Ann Arbor) would prohibit the sale of human organs by specifying that the procurement, processing, distribution and use of those organs is a service and not a sale. SB 481 is in the House Committee on Taxation. ☐

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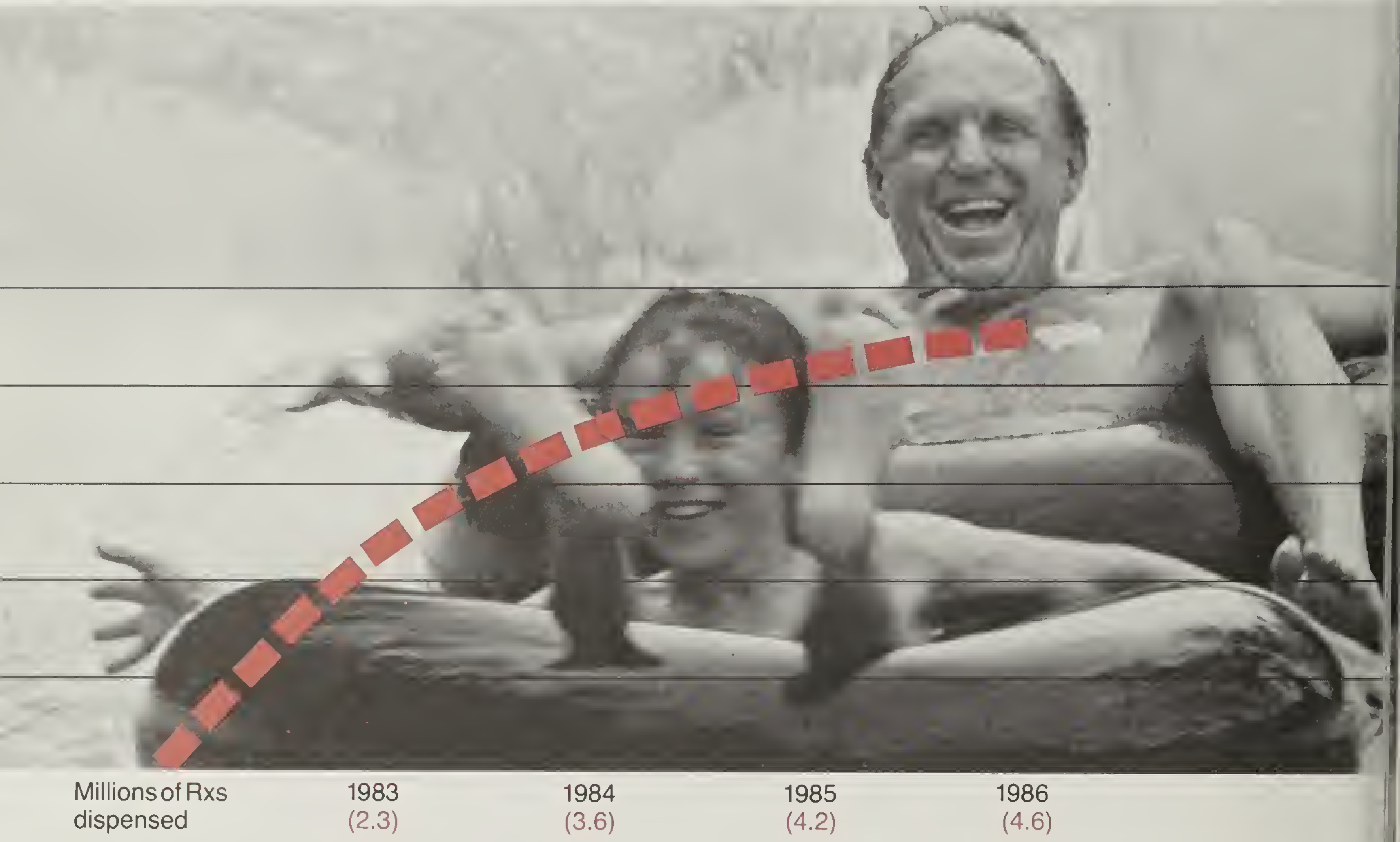

Transderm-Nitro®
nitroglycerin *2.5 mg/24 hr, 5 mg/24 hr, 10 mg/24 hr, 15 mg/24 hr*

the most prescribed long-acting nitrate*

*PDS data through May 1987.

Transderm-Nitro® **nitroglycerin**
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken A final evaluation of the effectiveness of the product will be announced by the FDA

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued In some patients, dermatitis may occur

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area

Transderm-Nitro system should not be applied to the distal parts of the extremities

The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs

Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems

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MSMS members have new group health option

By Betty J. McNerney, Managing Editor

For medical doctors, health care is a two-way street. While they devote their lives to providing health care, they, too, are receivers of care.

And, judging by the number of inquiries MSMS has received about its Health Insurance Benefit Program, many doctors are just as concerned about insuring quality health care for themselves as they are for others.

Administering the MSMS Blue Cross/Blue Shield Program is a new service offered by Physician Service Group (PSG) Inc., an MSMS subsidiary which offers physicians a variety of services designed to enhance their practices.

In 1987, MSMS received more than 5,000 inquiries regarding its Group Health Insurance Benefit Program—a number "far beyond" anything MSMS anticipated when it entered an agreement with Blue Cross and Blue Shield of Michigan (BCBSM) in 1986. (The agreement gave MSMS the responsibility of handling customer service aspects and promotion of the BCBSM plan.)

In addition, over 500 new contracts for health care insurance were signed in 1987. That brought the total number of contracts in the medical industry cluster to about 9,000.

Why the interest?

The MSMS Group Health Insurance Benefit Program has been widely used by MSMS members for a variety of reasons, according to John Richards, general manager of MSMS subsidiary operations.

First and foremost, the Group Health Insurance Plan "allows individual physicians to purchase health insurance for themselves and their employees as if they belong to a group," he said. "That is a major benefit to belonging to MSMS."

Another reason why the plan has been so well-received, according to Richards, is because MSMS has highly-trained people available to answer questions.

Policyholders and interested physicians can call 1-800-942-4141 to contact MSMS Group Health Insurance service representatives. In addition, MSMS has individuals available to visit and discuss with physicians options of the MSMS program.

"Personal touch" is key

Providing policyholders with "that personal touch" is really the key to the success of the program, says Mike Kelly, chief of insurance marketing for MSMS, who meets regularly with physicians and county medical societies regarding the Group Health Insurance Program.

"It is vitally important to our members to be able to pick up their phones, dial an 800 number and talk with an identifiable person," says Kelly. "Our members don't want to always speak with a different person when they call or be put on hold for 15 or 20 minutes."

"When our people tell you they're going to check something out, you can be guaranteed that it will be checked out, and you will get an answer to your question."

Kelly also said callers won't have to keep calling back and asking, "Do you remember me?" "We remember you," he said.

MSMS Group Health Insurance Service Representative Barbara Zimmerman agrees.

"We get so many people who have expressed appreciation for the continuity in servicing their accounts," she said.

Getting to know the service representatives makes callers feel

Committee input key to program's success

The new MSMS Group Health Insurance Benefit program would not have come into being without the tremendous help from members of the MSMS Group Health Insurance Advisory Committee. Committee members are: Jack L. Barry, MD, chairman; Leland E. Holly III, MD; B. David Wilson, MD; and William E. Madigan, MSMS executive director.

more secure about their problems, too, added Zimmerman.

Members do the choosing

Equally important as providing members with "that personal touch," according to Kelly, is providing them with a program they want.

"One of the things I stress to doctors is that this program was not picked by the MSMS staff," he said. "Physicians (members of the MSMS Group Health Insurance Advisory Committee and the MSMS Member Benefits Advisory Committee) picked this program and they did so after examining many health care programs."

Richards likes to stress to physicians that the trustees of the health insurance plan "spent many hours" ensuring the program's premiums are legitimate.

"They went through vast amounts of information prior to choosing this plan," he said.

One important point physicians should know, says Kelly, is that all the people associated with the MSMS Group Health Insurance Benefit Program are not BCBSM employees.

"We're physicians' allies, we don't work for BCBSM," he said.

"PSG is not an insurance agency," he said. "We work for the Michigan State Medical Society; that's important for physicians to know."□

Program features a variety of options

The MSMS Group Health Insurance Benefit Program offers members a variety of options. First, members have the option of choosing either Individual-Billed or Group-Billed coverage. Under the Individual-Billed coverage, members may choose one of three option plans. Under the Group-Billed coverage, members may choose one of four option plans.

Individual-Billed Options

As an MSMS member, you may protect yourself and your family with one of the following BCBSM Individual-Billed Option Plans:

Option I—Comprehensive Basic Plan providing first-dollar coverage for Hospital and Medical/Surgical coverage including a Catastrophic Master Medical provision.

Option II—Comprehensive Basic Plan similar to Option I, but you share the cost through a copayment. In this plan, BCBSM pays 80 percent of the cost for covered services; your copayment is 20 percent, with a stop-loss limit of up to $500 per member, $1,000 per family. After your 20 percent co-payment has reached the stop-loss limit, BCBSM pays 100 percent for the balance of the calendar year.

Option III—"Dimension III"—provides basic benefit and major medical type services similar to those in Option I; however, you share in the cost of covered services. A member deductible and copayment amount is included in the plan, which results in a lower monthly premium.

If you have enrolled or are enrolling now for BCBSM coverage through MSMS, your full-time employees are eligible to enroll in one of three special programs designed for them.

Group-Billed Options

If you prefer, you may enroll as a group. You are eligible with as few as two or as many as 99 employees. These specially-designed Group-Billed coverage options for MSMS members are not normally available to groups of this size.

You may select from four BCBSM plans: Comprehensive Basic Program (Options I, II, and III) or a Share-the-Cost Program (Option IV). You may also be eligible for the Dental or Vision Care Programs.□

MSMS answers your questions about health insurance

MSMS received over 5,000 phone calls in 1987 regarding its Group Health Insurance Benefit Program. Most of those who contacted MSMS sought answers to "general" questions about the program, often the same questions. Here's a rundown of the most frequently-asked questions, as compiled by Barbara Zimmerman, MSMS Group Health Insurance service representative.

Q: How long can my dependent child remain on my contract?

A: Dependent children are eligible for coverage through the end of the year they turn 19 years old.

Family Continuation Coverage is available to MSMS members enrolled in Option I and Option II at no additional cost to a family contract. Members' Option III coverage requires an additional charge for 19- to 25-year-old dependents. This rider provides coverage for young adults after the end of the year in which they turn 19. Notification will be sent to you by Blue Cross and Blue Shield of Michigan (BCBSM) when your dependent becomes eligible for family continuation coverage.

The eligibility requirements are:

- Unmarried
- Between the ages of 19 and 25 years
- Dependent on the member as defined by the Internal Revenue Service
- Dependents must reside with the subscriber.

Benefits for Family Continuation members are exactly the same as the subscriber's. Eligible dependents may be covered by this rider until they no longer meet the eligibility requirements or until the end of the year in which they attain age 25.

Family Continuation also is available to employees of MSMS members. There is an additional charge for each such dependent.

At the end of a dependent's 25th year they are automatically removed from the subscriber's contract. Subscribers may apply for a Sponsored Dependent Rider for an additional charge or dependents may enroll in their own BCBSM plan. Sponsored Dependents are not eligible for Master Medical or Prescription Drug Coverage.

Q: Who can enroll in the MSMS-sponsored BCBSM health care plan?

A: MSMS members, their families and their employees, the surviving spouse of a member and members of the American Association of Medical Assistants and eligible dependents may enroll providing the following requirements are met:

Members

- Physicians must be active, associate, military, retired or life members of MSMS residing permanently or practicing in Michigan.
- Dues must be paid prior to annual inventory.
- Physicians are not eligible for coverage in the employee group.

Employees

- Employees must work at least 30 hours per week for a member of MSMS who has BCBSM through some source.
- Employees are not eligible for coverage upon retirement.

Continued on page 88

When you get sick, everyone loses.

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New licensure rules

By Thomas J. DeKornfeld, MD

By the time you read this column, the rules for physician licensure, both by examination and by endorsement, will be new and different from the ones that you are familiar with. Since both these sets of rules are of considerable importance to many physicians in Michigan, I thought it would be well worthwhile to devote a column to them and to explain in simple, non-technical language what the new rules mean.

Let me make some general comments first.

At the December 17, 1987 meeting, the Michigan Board of Medicine formally adopted the amendments to the General Rules. In plain language this means that the "NEW" rules of licensure had been submitted to the Governor's office and fifteen days after they had been filed with the Secretary of State.

Under the new rules, the Michigan Board of Medicine is completely out of the medical school- and hospital-approval business for graduates of foreign medical schools. Further, it will be less cumbersome for all applicants to be licensed in Michigan. This is particularly true for graduates of foreign medical schools, since the rules for the graduates of US and Canadian medical schools have been changed and made less cumbersome. The documentation required has been reduced and licensure by endorsement has been streamlined.

All physicians admitted to training in Michigan and issued an educational limited license will be eligible for a permanent license, provided they pass FLEX with a grade of 75 or better and serve the required period of time in postgraduate clinical training.

The requirement for the period of time in graduate training has not changed. It is the same under the new rules as it was under the rules which had been promulgated in May 1986 and which have now been amended.

> **"Under the new rules, the Michigan Board of Medicine is completely out of the medical school — and hospital — approval business for graduates of foreign medical schools."**

Let us now look at specifics. The requirements for an **Educational Limited License** are: **Graduates of US and Canadian medical schools:**

1. Graduation from an LCME accredited school.
2. Acceptance into an ACGME-accredited program.
3. Filing of an application and payment of fee.

Graduates of foreign medical schools:

1. Completion of the requirements for a degree in medicine. This is defined to mean that the applicant has completed courses in the basic sciences (anatomy, physiology, biochemistry, microbiology, pathology, pharmacology, and therapeutics, and preventive medicine) and the clinical sciences (clinical clerkships in medicine, surgery, pediatrics, obstetrics and gynecology, and psychiatry.)

All of these clinical clerkships must be served in hospitals that are either accredited by the JCAH or have graduate training programs in the content areas of the clinical clerkships. The total length of the medical curriculum must be at least 130 weeks.

2. Show evidence that the applicant has taken and passed the examination offered by the ECFMG.
3. Acceptance into an ACGME accredited program.
4. Filing an application and payment of fee.

Requirements for a Permanent (unrestricted) License are: **US and Canadian graduates: (In addition to the requirements for an educational limited license:)**

1. One year of ACGME accredited training.
2. FLEX or National Boards.

Foreign medical school graduates (in addition to the requirements for an educational limited license):

1. Three years of ACGME accredited training.
2. FLEX or FLEX I & FLEX II.

Doctor DeKornfeld is administrator, Michigan Board of Medicine.

Continued on page 96

III

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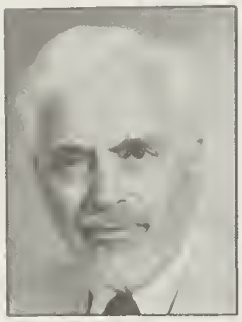
Agranoff

Vasileff

Bort

Luk

Evangelista

Netzloff

Bernard W. Agranoff, MD, Ann Arbor, professor of biological chemistry and psychiatry at the University of Michigan Medical School, has been named the U-M's 1988 Henry Russel Lecturer. The annual lectureship is the school's highest honor given to a senior faculty member.... **William J. Vasileff, MD**, Birmingham, became a Fellow of the American College of Surgeons, the largest organization in the world, during the college's 73rd Annual Clinical Congress on October 15.... **Robert Bort, MD**, North Lake, recently returned from a three-week visit to the People's Republic of China. Doctor Bort, director of psychiatric services at Jackson Prison, participated in a China/United States conference sponsored by the Chinese Hospital Management Society and was co-presenter of a paper *Managing A Modern Correctional Hospital*.... **Lloyd Wiegerink, MD**, West Branch, former director of public health in Ogemaw County, conducted a seminar on the Agent Orange program questionaire on December 12, in Prescott, that was mailed to over 161,000 Viet Nam veterans by the Michigan Department of Health.... **June E. Osborn, MD**, Ann Arbor, dean of the School of Public Health, University of Michigan, presented an overview October 29 at the University Club, of the status of the AIDS epidemic and the issues surrounding AIDS-related testing, screening and reporting.... **Gordon Luk, MD**, Bloomfield Hills, chief of gastroenterology at Harper Grace Hospitals has been elected governor of the American College of Gastroenterology representing Michigan. Doctor Luk will be responsible for acting as a liaison, to encourage post graduate education.... **Stanley K. Saunders, MD**, Southfield, has received recognition from Special Olympics International, the headquarters of the worldwide sports program for the mentally impaired. Doctor Saunders has been named Volunteer of the Year.... **Jose L. Evangelista, MD**, Livonia, headed the Annual Medical Surgical Missions to the Philippines last December. Doctor Evangelista is the current president of the Association of Philippine Physicians in America, a national organization composed of 13,000 Philippine physicians in the United States. It is the largest and most organized ethnic association in the United States. ... **William N. Hubbard, MD**, Hickory Corners, is a member of the W. K. Kellogg Foundation board of Directors. He recently was appointed to the Board's Finance Committee.... Oakwood Hospital, Dearborn, announces the appointment of **Federico G. Mariona, MD**, of Detroit, to director, Maternal-Fetal Medicine Division. Oakwood Hospital is a Level III perinatal and obstetrical referral center. Its Division of Maternal-Fetal Medicine specializes in the management of high-risk pregnancies.... **Michael Netzloff, MD**, East Lansing, has been named chairman of Michigan State University's Department of Pediatrics and Human Development. Doctor Netzloff also has served as director of MSU's Division of Human Genetics, Genetic Toxicology, Endocrinology and Oncology. □

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

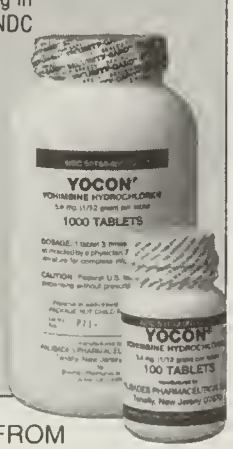
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon™ 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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QUESTIONS/Continued

SURVIVING SPOUSE

- Must be on the contract of an MSMS member as of the date of death.

American Association of Medical Assistants

- AAMA members must work at least 30 hours per week for a member of MSMS, but the member does not have to be enrolled with BCBSM.
- AAMA members are not eligible for coverage upon retirement.

Michigan residency is required in all groups

Q: When will my coverage become effective?

A: Coverage-effective dates are based on a continuous enrollment schedule. (There may be a waiting period up to 120 days if you don't currently have BCBSM coverage.) You also may transfer from your current BCBSM group at the paid-to-date in that group.

Q: What should I do if I have a question on a claim?

A: For general information on a specific claim—or to verify payment of a specific claim—you should call BCBSM Customer Service in your area.

If you think the decision made by BCBSM on your claim is incorrect, you may request a review by writing to: BCBSM, Customer Service Department, P.O. Box 2888, Detroit, MI 48231.

This must be done within 60 days of payment or rejection of the claim. Be sure to include name, contract and group number, your daytime telephone number and the date of service in question. Also include any documents or comments that might help resolve the case and an explanation of why you think the claim should be settled differently.

Still have questions?

Please contact the MSMS Group Health Insurance Representatives at 1-800-942-4141 (8:30 a.m.-noon; 1:00 p.m.-5:00 p.m.) if you have any questions regarding your health care coverage. ☐

A guide for determining medical/legal fees

Editor's note: These guidelines have been approved by the Michigan State Medical Society, the State Bar of Michigan and the Michigan Association of Osteopathic Physicians and Surgeons.

Physicians are often asked to provide medical records, narrative reports, consultations and testimony concerning their patients. The following guidelines have been prepared[1] to assist physicians in determining appropriate fees for these services.[2] Additional information may be found in the "Inter-Professional Code for Oakland County Physicians and Attorneys" (1983). Sample formats follow this text.

No effort is made to suggest actual fees as this is the prerogative of the parties involved.

(A) **Fees For Furnishing Existing Records:** A request for copies of medical records[3] should be treated and billed as a clerical function, not a physician service. Since a certain amount of time is required to locate, identify and send out medical records, whether one page or many, a flat fee for locating and sending the records, plus a nominal per-page increment for copying, is reasonable.[4]

(B) **Fees For A Narrative Report:** A narrative report is a report prepared by a physician in response to an inquiry for patient information, containing a review of the patient's history, initial examination, diagnosis, course of treatment, prognosis and, if requested, relationship to incident or event.

It is reasonable to charge on either an hourly- or flat-rate basis for the preparation of a report. In determining the hourly rate to be used, the physician should consider the fact that the time spent preparing narrative reports need not conflict with hospital, surgical or patient examining time.[5]

> **"In determining the hourly rate to be used, the physician should consider the fact that the time spent preparing narrative reports need not conflict with hospital, surgical or patient examining time."**

Many physicians prefer to charge a flat fee for a narrative report, rather than compute a precise fee based on time spent.[6] This practice is reasonable, provided that:

(1) The flat rate is arrived at by determining the amount of time spent for the preparation of a typical narrative report multiplied by a reasonable hourly rate; and,

(2) Where the actual time spent on a report is far in excess or below the average, the flat fee may be adjusted accordingly.

(C) **Fees For Conferences:** When an attorney wishes to meet with a physician, it is reasonable for the physician to charge for that conference on an hourly basis.[7]

(D) **Fees For Deposition Testimony:** Depositions impose greater demands upon the time and scheduling convenience of the physician than do narrative reports.[8] Deposition charges may include travel time, research, and pre-deposition conference time. It is reasonable to charge a somewhat higher hourly fee for the deposition itself. It is common for a physician to charge a stated amount for the deposition which includes the first hour of time with an additional hourly charge for depositions that run beyond the first hour.

A cancellation fee is reasonable where notice of the cancellation policy is given in advance. A cancellation fee should not be charged if notice of cancellation is given sufficiently in advance to allow the physician to reschedule the time in a productive manner.

(E) **Fees For Courtroom Testimony:** Courtroom testimony will frequently involve a serious disruption to a physician's practice. Where a physician can be placed on call, and can continue daily business until actually needed in court, waiting time should not incur additional charges. If any attorney requests that a physician

Continued on next page

FEES/Continued

come to court and wait to testify, or where a physician's schedule must be cleared in anticipation of being called, it is reasonable that the physician be paid for waiting time as well as testimony time.

(F) **Agreement in Advance:** Misunderstandings and disputes over fees can usually be avoided if fees and cancellation charges are agreed upon in advance between the physician and the attorney.

FOOTNOTES

(1) These guidelines are a cooperative effort of the Oakland County Bar Association, the Oakland County Medical Society, and the Oakland County Osteopathic Association, to balance the interests of physicians who, often times, have no desire to be involved in legal matters in the first place, and attorneys who, in the representation of their clients, have no choice but to call upon a physician who has already rendered an examination or treatment to the patient/client. Both parties must realize that a physician's time is valuable, but that the patient/client ultimately pays those charges by law, whether the ultimate recovery to the client is large or very small. The organizations involved have attempted to balance these conflicting problems in these guidelines.

It is not the intent of this document to suggest when a physician should or should not release information. Those matters are the subject of doctor-patient privilege and are well handled elsewhere.

The question these guidelines address is how to charge an appropriate fee for providing information which may or may not require the addition of professional time for interpretation.

(2) Although these guidelines may be useful for setting any medical/legal fee, they are less important in the situation where an attorney specifically retains a doctor on a medical/legal matter who has had no prior contact with the patient, but is being retained solely by reason of his expertise in the field. In this situation, the physician having the ultimate right to refuse the work altogether may set the price within a wider range. The requesting party, if dissatisfied, can simply take the business elsewhere.

"It is not the intent of this document to suggest when a physician should or should not release information. Those matters are the subject of doctor-patient privilege and are well-handled elsewhere."

The physician who has already seen the patient for purposes of medical treatment is in a different position. He may well be the sole source of the information needed in the preparation of the client's case. The requesting party has no alternative but to employ the services of that physician subject to the following limitations:

a) He may subpoena records (if the matter is in suit) and pay only standard copying charges; and
b) If the physician is called to testify, the court has ultimate jurisdiction over the fees charged pursuant to statute and court rules.

If the attorney resorts to the court's subpoena powers, the resultant hostility between the physician and the attorney can jeopardize the patient's interest. These guidelines are especially intended to assist physicians in dealing with a determination of fees in this context.

(3) Records include not only office notes, but copies of hospital summaries and reports prepared for referring physicians, insurance companies, etc.

(4) A request to merely photocopy records and send them out (accompanied by the appropriate authorization) should be the easiest request to fulfill and the least expensive for the requesting party for the reason that a clerical function should not be equated with professional time in determining the fee to be charged. Most charts can be located, copied and mailed in less than a half hour. A flat administrative

Sample Format Of A Medical Information Response From Physician To Attorney

To:____________________ From:____________________

Patient:____
(name and address)

RE: Policies regarding Evaluations, Reports and Testimony

This office is willing to cooperate with you on evaluations, preparations of reports and/or testimony. The following policies have been established as suggested by the Oakland County Medical Society, the Oakland County Bar Association, and the Oakland Osteopathic Association.

1. **Evaluations and Reports:**
   We are willing to perform medical evaluations and prepare reports for your use. The costs shall be individually determined. These evaluations can be scheduled by phone; however, we expect a written request with an appropriate authorization for release of information prior to the patient being seen.

2. **Records/Reports Without New Evaluations:**
   We will prepare copies of records, or reports on patients, and we expect payment for these in advance. However, we will not deposit your check until the information requested has been mailed.

3. **Depositions:**
   Depositions will be scheduled at mutually convenient times. Upon confirming the scheduling of a deposition, we request payment for an hour of the doctor's time. Depositions lasting longer than an hour will be billed accordingly. Such payment should be guaranteed by the requesting lawyer in writing. The postponement and/or cancellation policy is:____________________
   ____

4. **Court Appearance:**
   Court appearance will be provided at your request. The fee for the appearance will be determined from portal-to-portal. The estimated fees for preparation will be determined in advance. The postponement and/or cancellation policy is:
   ____
   ____

5. **Fee:**
   My fee for your requested service is____________________ .
   We expect payment for services in advance. However, we will not deposit your check until the report has been mailed. Further requests for additional information will be billed accordingly.

6. **Assignment:**
   Your client has an account overdue in this office of $____________________ .
   If litigation ensues, we would appreciate being notified of this, and any settlement or judgement rendered. Your help in protecting our fees is appreciated.

If you have any questions, please contact my office.

PHYSICIAN TO ATTORNEY
LETTER/Continued

***FEES:**

Record Copying:

Search Fee________________ $________

Page Fee________________ $________ per page

**Evaluation________________ $________ -$________

**Report________________ $________ -$________

Evaluation & Report________________ $________ -$________

Consultation & Preparations________________ $________ -$________

$________ per ½ day

$________ per day & expenses

***Deposition________________ $________ first hour

Cancellation/Postponement Policy:________________________________

____

*Includes overhead costs.
**Note: x-rays, laboratory work, etc., may be billed separately.
***Subject to court approval.

REFERENCE: "Suggested Guidelines For Determining Medical/Legal Fees," established by the Oakland County Medical/Legal Committee, and published in: *Michigan Medicine*, February 1988.

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1866

AIM HIGH

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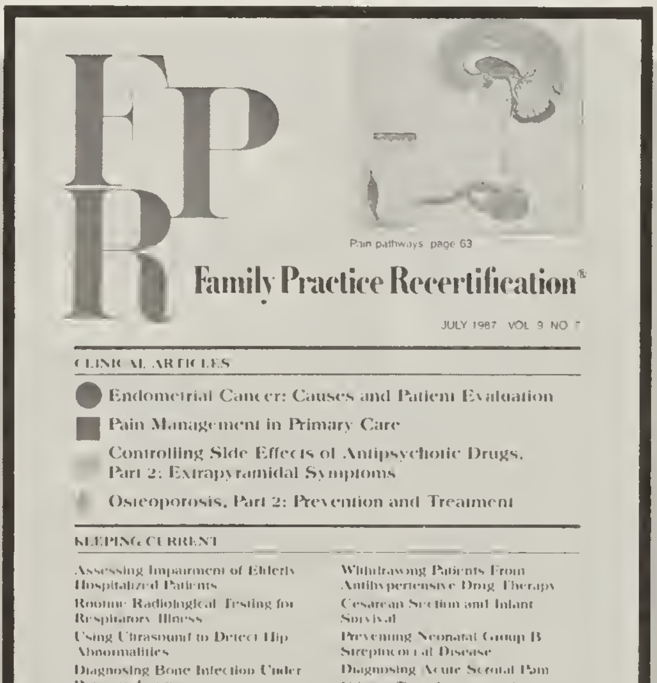

FPR

Pain pathways page 63

Family Practice Recertification®

JULY 1987 VOL 9 NO 7

CLINICAL ARTICLES

● Endometrial Cancer: Causes and Patient Evaluation

■ Pain Management in Primary Care

Controlling Side Effects of Antipsychotic Drugs, Part 2: Extrapyramidal Symptoms

Osteoporosis, Part 2: Prevention and Treatment

KEEPING CURRENT

Assessing Impairment of Elderly Hospitalized Patients

Routine Radiological Testing for Respiratory Illness

Using Ultrasound to Detect Hip Abnormalities

Diagnosing Bone Infection Under Pressure Sores

Slowing Progression of Diabetic Nephropathy

Behavioral Disorders Among Children of Alcoholic Fathers

Catheter Related Septic Central Venous Thrombosis

Withdrawing Patients From Antihypertensive Drug Therapy

Cesarean Section and Infant Survival

Preventing Neonatal Group B Streptococcal Disease

Diagnosing Acute Scrotal Pain

Urinary Tract Infections Among Uncircumcised Infants

Colonoscopy: Detecting Recurrent Colorectal Cancer

Surgical Management of Chronic Intestinal Ischemia

Preventing Travelers' Diarrhea

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DEKORNFELD/Continued

The rules for admission to the FLEX EXAM also have been markedly eased in the new rules. American and Canadian graduates can now take FLEX I within six months of graduation from medical school. FLEX II can be taken after six months of graduate training. It does not matter in what sequence the exams are taken, where they are taken or whether they are taken at one sitting or not.

Foreign medical graduates must show that they have passed the ECFMG exam before they will be admitted to FLEX in Michigan. If a candidate is unable to pass both FLEX I and II within five years from the date that he/she has first taken either part of the examination, or FLEX, he/she must take one additional year of graduate training before he/she can sit again.

The **Clinical Academic Limited License** rules were rescinded, and so were the rules for the **Non-Clinical Limited License.**

As far as the **Endorsement Rules** are concerned, these also have been simplified.

An endorsement application will be acceptable if the applicant has been licensed in another US jurisdiction before January 1, 1977, and has been in practice for 10 years.

If the applicant was licensed after January 1, 1977, or has not engaged in the practice of medicine for 10 years, he/she must show that he/she was licensed in the other state on the basis of an examination substantially equivalent to the examination required for licensure by examination in Michigan at that time.

In addition, applicants must show that by the time they apply for a license by endorsement they have had one year of postgraduate training, if US or Canadian graduates, and three years of postgraduate training if graduates of a foreign medical school, provided the graduate of the foreign medical school had received his license in the other state after May 19, 1986.

If the foreign medical graduate obtained his/her license in the other state prior to May 10, 1986, only one year of postgraduate training is required. Foreign medical graduates also must show evidence of having taken and passed the ECFMG or FMGEM or VQE examination.

Nobody claims that these rules are perfect, but they are a tremendous improvement over the May 1986 rules. They represent the Board's deep concern for the health, welfare and safety of the people of Michigan, while doing everything within reason to attract competent physicians to the State and to make the licensure process as fair, as equitable and as free of bother as possible. ☐

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potassium chloride
slow-release tablets
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*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.
Before prescribing, please consult Brief Prescribing Information on next page.

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For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company **2.** Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety *Pharmacotherapy* 1980;4(6):392-397. **3.** Skoutakis VA, Carter CA, Acchiardo SR Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics *Drug Intell Clin Pharm* 1987;21 436-440

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function, potassium-losing nephropathy; and certain diarrheal states.

3 The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e g , spironolactone, triamterene) (see OVERDOSAGE)

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e g , spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic *acidosis* should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed

Laboratory Tests

Regular serum potassium determinations are recommended In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis

Drug Interactions

Potassium-sparing diuretics: see WARNINGS

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L It is not known if Slow-K has an effect on this content Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose

Skin rash has been reported rarely

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS) It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L)

Treatment measures for hyperkalemia include the following (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate, (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

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Bottles of 1000	NDC 0083-0165-40
Consumer Pack—One Unit	
12 Bottles—100 tablets each	NDC 0083-0165-65
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Do not store above 86°F (30°C) Protect from moisture. Protect from light.

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C I B A

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IN MY OPINION/Continued

less dangerous and costly protocols.

The structure of financial incentives for gatekeeping physicians clearly must not include compensation directly related to reduction of services for specific patients. The educational needs for this type of practice are enormous and will include opportunities for sharing experiences, orientation programs, and discussions aimed toward sensitivity to the value trade-offs of treatment and the complex mix of factors affecting the morale of patients who are being "case-managed." From the patients' perspective being "managed" is often a negative.

I feel tipping the scale from the influence of "prudent buyers" which emphasize financial savings toward optional patient care, is the peculiar role of all of us in the physician community.

How to maximally-develop and implement that role and thereby integrate financial and patient-care values, is a very complex question.

Physicians must dedicate the time and energy to be active in policy development—in private, public, local and national settings. This is absolutely essential if we are to sustain the credibility of our profession. We must not abrogate leadership in decisions about delivery of medical care to bureaucratic theorists who have never had any involvement in delivering that care! ☐

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DEATHS

Claire H. Clausen, MD
Chippewa

Doctor Clausen died October 20 at the age of 90. He was past president of the Upper Peninsula of Michigan Medical Society and had been affiliated with War Memorial Hospital in Sault Ste Marie. A Board-certified radiologist, he was a member of the American College of Radiology and the Radiology Society of North America. He was a 1924 graduate of Wayne State University.

Richard C. Deming, MD
Jackson

Doctor Deming, an orthopedic surgeon who practiced in Jackson for more than 30 years, died November 14 at the age of 73. He was Jackson's first orthopedic surgeon to be certified by the state to conduct monthly clinics on behalf of the Jackson County Crippled Children's Society, which he founded. He also helped introduce Jackson to total hip replacements, and was involved in establishing a hospital in Nigeria. He was a member of the AMA, MSMS and the Jackson County Medical Society.

Kenneth E. Fellows, MD
Spring Lake

Doctor Fellows, a retired Grand Rapids radiologist, died December 20 at the age of 81. He graduated from the University of Michigan Medical School. He served his residency at Blodgett Hospital where he was the assistant director of the relief clinic. In 1937, he entered a Grand Rapids private practice in radiology which he maintained until his retirement in 1977. He was a member of the American College of Radiologists and the American Medical Association.

Leon Fill, MD
Huntington Woods

Doctor Fill, hospital founder, chairman of the board and president of Madison National Bank, died November 19 at the age of 73. A graduate of the University of Wisconsin and the Laval Medical School in Quebec, Canada, he was an obstetrician and gynecologist. Doctor Fill was founder of Martin Place Hospital, with locations in Detroit and Madison Heights. He also served in the Army Medical Corps during World War II, and was awarded the Bronze Star and two Purple Hearts.

Donald K. Freeman, MD
St. Clair Shores

Doctor Freeman died December 10 at the age of 78. He graduated from the University of North Dakota and earned his medical degree from the University of Louisville in 1933. He was affiliated with Bon Secours, Grosse Pointe, Deaconess and Eastside General hospitals, in Detroit.

Herbert T. Iwate, MD
Riverview

Doctor Iwate died October 24 at the age of 71. He received a medical degree from the University of Michigan Medical School and served his residency at Detroit Memorial and Herman Keifer hospitals. Doctor Iwate was a captain in the Army medical corps during the Korean war. He was a member of the American Medical Association and practiced in the Professional Building in Detroit.

Oscar B. Kahn, MD
Capac

Doctor Kahn, a general practitioner, died December 17 at the age of 70. He attended Michigan State University and earned his medical degree from Wayne State University. He served on staff of Yale Community Hospital. He also served in the U.S. Navy as a medical military servant.

Lightbody

James J. Lightbody, MD
Detroit

Doctor Lightbody, past MSMS president and Detroit physician, died November 24 at the age of 83. He was co-founder of the Michigan Arthritis Foundation and served as its medical director for 20 years, supervising its research and fellowship programs.

Continued on page 109

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

March

10-15, Ophthalmology: Basic and Clinical Review Course. Location: Hotel Pontchartrain, 2 Washington Boulevard, Detroit. **Sponsor:** Kresge Eye Institute of Wayne State Univesity School of Medicine. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, 4H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180. **Approved for:** 42 hours Category 1 Credit.

13-18, Emergencies in Medicine. Location: The Yarrow, A Dunfey Resort and Conference Center, Park City, Utah. **Sponsor:** Michigan Committee on Trauma, American College of Surgeons. **Contact:** Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit 48201 (313)745-3484. **Approved for:** 25 hours Category I Credit.

15, Patient Care for Practicing Physicians. Location: Clarion Conference Center, 6810 S. Cedar Street, Lansing. **Sponsor:** Ingham County Medical Society and MSMS Committee for Continuing Medical Education. **Contact:** Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)334-2320. **Approved for:** 6 hours Category I Credit.

16-18, A Symposium and Preceptorship in Diabetes Care. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School. **Contact:** Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 19 hours Category I Credit.

20-25, Facial Cutaneous Surgery: Mohs, Reconstructive, and Cosmetic. Location: Copper Mountain Resort, Copper Mountain, Colorado. **Sponsor:** The University of Michigan Medical School. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 19 hours Category I Credit.

22-26, Family Practice—1988 Twelfth Annual Spring Refresher and Board Examination Review. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Family Practice and The Michigan Academy of Family Physicians. **Contact:** Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 33.75 hours Category I Credit.

23-24, 27th Annual Conference on Maternal and Perinatal Health: Issues in Primary Perinatal Practice. Location: Amway Grand Plaza, Grand Rapids. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, Chief, Physician Education, Michigan State Medical Society, P.O.Box 950, East Lansing 48826-0950 (517)337-1351. **Approved for:** 13 hours Category I Credit.

April

8-9, Advanced Trauma Life Support Instructor Course. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School. **Contact:** Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 18 hours Category I Credit.

10-13, Extracorporeal Membrane Oxygenation for Neonatal Respiratory Failure (ECMO) Basic and Advanced Courses. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Departments of Surgery, Pediatrics and Communicable Diseases. **Contact:** Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 15 hours Category I Credit for the basic course and 7 hours Category I Credit for the advanced course.

13, Educational and Health Perspectives of Dyslexia. Location: Western Michigan University, Kalamazoo. **Sponsor:** Michigan Dyslexia Institute, Michigan Department of Public Health, Michigan Branch of the Orton Dyslexia Society, SLD Center of Kalamazoo. **Contact:** Alice Hamachek, Michigan Dyslexia Institute, P.O.Box 23025, Lansing 48901 (517)349-6522. **Approved for:** 5 hours Category I Credit.

14-15, Annual Postgraduate Course in Obstetrics and Gynecology: Challenges and Changes of the 1980s. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Obstetrics and Gynecology. **Contact:** Betty Phillips, Office of Continuing Medical Education, The Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 15 hours Category I Credit.

16, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians. **Contact:** Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. **Approved for:** 5 hours Category I Credit.

18-20, Ultrasound in Obstetrics and Gynecology. Location: The Towsley Center for Continuing Medical Education, The University of Michigan Medical School. **Sponsor:** The University of Michigan Medical School, Department of Radiology. **Contact:** Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 22 hours Category I Credit.

19, Is There a Difference Between the Practice of Medicine and the Practice of Osteopathy? Location: Clarion Conference Center, 6810 S. Cedar Street, Lansing. **Sponsor:** Ingham County Medical Society and MSMS Committee for Continuing Medical Education. **Contact:** Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing

48910 (517)334-2320. Approved for: 6 hours Category 1 Credit.

20, Sleep Throughout the Life Cycle. Location: Fetzer Center at Western Michigan University, Kalamazoo. Sponsor: Borgess Pulmonary Services. Contact: Judy Smith, Pulmonary Services, Borgess Medical Center, Kalamazoo (616)383-4875. Approved for: 6 hours Category I Credit.

21-23, Michigan Association of Osteopathic Physicians and Surgeons, Inc. 89th Annual Post-Graduate Conference and Scientific Seminar. Location: Hyatt Regency Dearborn at Fairlane Town Center. Sponsor: Michigan Association of Osteopathic Physicians and Surgeons, Inc. Contact: Cathi A. Liebziet, Michigan Osteopathic Journal, 33100 Freedom Road, Farmington 48024 (313)476-2800. Approved for: 29 hours Category I-A Credit.

28-29, The Phlebotomy Team: Technical and Management Perspectives. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Pathology. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 201, Ann Arbor 48109-0201 (313)763-1400. Approved for: 11 hours Category I Credit.

May

4-5, Computed Tomography and Magnetic Resonance Imaging and Radiologic Technologist Program. Location: The Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Radiology. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 22.5 hours Category I Credit.

5-7, National Conference on Health Care Leadership and Management. Location: Sheraton Harbor Island, San Diego, CA. Sponsor: The American Academy of Medical Directors. Contact: Sherry Mason, AAMD, 4830 W. Kennedy Blvd, Suite 648, Tampa, FL 33609-2517 (813)287-2000. Approved for: 16 hours Category 1 Credit.

16th Annual Spring Update: Advances in Internal Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Internal Medicine. Contact: Gayle Fox, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 34 hours Category I Credit.

16-17, Recent Trends in the Electrophysiologic Assessment of Auditory Function: Neuro-Otologic and Intraoperative Applications; Pediatric and Neonatal Applications. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Otolaryngology. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

19, MSMS Sports Medicine Conference. Location: Hilton Inn, 7501 Saginaw, Lansing. Sponsor: Michigan State Medical Society. Contact: Sherry L. Fent, Chief, Physician Education, Michigan State Medical Society, P.O. Box 950, East Lansing, 48826-0950 (517)337-1351. Approved for: 5 hours Category I Credit.

June

2-3, 14th Annual Kalamazoo Symposium for Michigan Neonatologists and Neonatal/Perinatal Medicine Fellows. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. Sponsor: Neonatology Service of the Pediatric Section —Bronson Mead Johnson Laboratories. Contact: John Hartline, MD, Neonatology Service of the Pediatric Section, Bronson Methodist Hospital, 252 East Lovell Street, Kalamazoo 49007 (616)341-6469. Approved for: 7.25 hours Category I Credit.

3, Seventh Annual Cleft Palate Symposium. Location: Waterfront Inn, Traverse City. Sponsor: Michigan Cleft Palate Association, Center for Human Services, Western Michigan University. Contact: Janet Wilson, Center for Human Services, Western Michigan University, Kalamazoo 49008 (616)383-4941.

21, Preventive Oncology. Location: Clarion Conference Center, 6810 S. Cedar Street, Lansing. Sponsor: Ingham County Medical Society and MSMS Committee for Continuing Medical Education. Contact: Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)332-2320. Approved for: 6 hours Category I Credit.

July

21-24, Fifteenth Michigan Emergency Medicine Assembly: EMS Concepts 88 and Base Station Symposium. Location: Hilton Shanty Creek, Bellaire. Sponsor: Michigan Chapter of the American College of Emergency Physicians. Contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. Approved for: 22 hours Category 1 Credit.

28-29, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Grand Traverse Village. Sponsor: Munson Medical Center. Contact: Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City 48684-2386 (616)922-9546. Approved for: 13 hours Category I Credit.

October

1, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw. Sponsor: Michigan Chapter of the American College of Emergency Physicians. Contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. Approved for: 5 hours Category I Credit.

"Good morning . . . the doctor said he wanted you shot at 6 a.m.!"

MEETINGS

MICHIGAN STATE MEDICAL SOCIETY
1866

MSMS MEETINGS

March

2, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

23-24, 27th Annual Conference on Maternal and Perinatal Health: Issues in Primary Perinatal Practice, Amway Grand Hotel, Grand Rapids, contact: Sherry L. Fent, (517)337-1351.

April

29-5/1, MSMS Board of Directors and House of Delegates, Hyatt Regency, Dearborn, contact: William Madigan (517)337-1351.

May

19, MSMS Sports Medicine Conference, Hilton, Lansing, contact: Sherry L. Fent (517)337-1351.

September

14, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

November

8-10, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent (517) 337-1351.

16, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

AMA MEETINGS

March

3-4, American Medical Association and the Institute of Food Technologists, Concerns About the Safety of the Food Supply in the 21st Century, Crystal Gateway Marriott Hotel, Arlington, VA, contact: Andrew Skolnick, American Medical Association, Department of Public Information, 535 North Dearborn St., Chicago 60610 (312)645-4843.

June

26-30, AMA Annual Meeting, Chicago Hilton and Towers, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4392 (312) 645-4344.

December

6-9, AMA Interim Meeting, Atlanta, GA contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4344.

MICHIGAN SPECIALTY SOCIETY MEETINGS

April

16, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500.

June

17-19, Annual Meeting—Michigan Association of Neurological Surgeons, Grand Traverse Resort, Traverse City, contact: William F. Chandler, MD, 1500 E. Medical Center Drive, Ann Arbor 48109 (313)936-5020.

July

21, Fifteenth Michigan Emergency Medicine Assembly—EMS Concepts 88 and Base Station Symposium, Michigan Chapter of the American College of Emergency Physicians, Hilton Shanty Creek, Bellaire, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500.

October

9, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500.

NATIONAL SPECIALTY SOCIETIES

March 3-6, American College of Physicians Annual Meeting, New York, NY, contact: American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104 (215) 243-1200.

20-23, American Society of Abdominal Surgeons Annual Scientific Meeting, Williamsburg Hospitality House, Williamsburg, VA, contact: American Society of Abdominal Surgeons, 675 Main Street, Melrose, MA 02176 (617)665-6102.

27-30, American College of Emergency Physicians Annual Meeting, Hotel Del Coronado, Coronado, CA, contact: American College of Emergency Physicians, P.O. Box 611911, Dallas, TX 75261-9911 (214)550-0911.

27-31, American College of Cardiology Scientific Meeting, Atlanta, GA, contact: American College of Cardiology, 9111 Old Georgetown Road, Bethesda, MD 20814 (301) 897-5400.

April

14-17, American College of Preventive Medicine Annual Scientific Meeting, Westin Peachtree Plaza, Atlanta, GA, contact: American College of Preventive Medicine, 1015 15th Street, N.W., Suite 403, Washington, DC 20005 (202) 789-0003.

17-23, American Academy of Neurology Annual Meeting, Convention Center, Cincinnati, OH, contact: American Academy of Neurology, 2221 University Avenue, S.E., Suite 335, Minneapolis, MN 55414 (612)623-8115.

18-20, American Association for Thoracic Surgery Annual Scientific Meeting, Century Plaza, Los Angeles, CA, contact: American Association for Thoracic Surgery, 13 Elm Street, Manchester, MA 01944 (617)927-8330.

23-29, American Occupational Medical Association Annual Meeting, New Orleans Marriott, New Orleans, LA, contact: American Occupational Medical Association, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312)228-6850.

24-28, American Association Neurological Surgeons Annual Meeting, Toronto, Ontario, contact: American Association Neurological Surgeons, 22 S. Washington, Suite 100, Park Ridge, IL 60068 (312) 692-9500.

29-30, American Academy of Facial Plastic and Reconstructive Surgery Interim Meeting, The Breakers, Palm Beach, FL, contact: American Academy of Facial Plastic and Reconstructive Surgery, 1101 Vermont Avenue, N.W., Suite 404, Washington, DC 20005 (202) 842-4500.

May

1-4, American Association of Plastic Surgeons Annual Scientific Meeting, The Breakers, Palm Beach, FL, contact: American Association of Plastic Surgeons, University of Chicago, Box 269, 5841 S. Maryand Avenue, Chicago, IL 60637 (312)962-6302.

1-5, American College of Obstetricians and Gynecologists Annual Scientific Meeting, Boston Sheraton, Boston, MA, contact: American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SW, Suite 300 East, Washington, DC 20024 (202)638-5577.

1-6, American Association of Pathologists Annual Scientific Meeting, Las Vegas, NV, contact: American Association of Pathologists, 9650 Rockville Pike, Bethesda, MD 20814 (301)530-7130.

2-4, Consensus Development Conference on Cochlear Implants, National Institute of Health, Bethesda, Maryland, contact: Michael J. Bernstein, Office of Medical Applications of Research, National Institutes of Health, Bethesda, Maryland 20892 (301)496-1143.

7-13, American Psychiatric Association Annual Scientific Meeting, Le Sheraton Centre, Montreal, Canada, contact: American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005 (202) 682-6000.

19-22, American Geriatrics Society Annual Meeting, Disneyland Hotel, Anaheim, CA, contact: American Geriatrics Society, 770 Lexington Avenue, Suite 400, New York, NY 10021 (212)688-2150.

OTHER MEETINGS

April

6-7, Southeastern Michigan Medical Expo 88: Quality Medicine of the 90s, Wayne County Medical Society, contact: Wayne County Medical Society Service Bureau, Inc., 1010 Antietam Road, Detroit 48207 (313)567-1640.

25-26, Twelfth Annual Conference of the Michigan Association for Infant Mental Health, Ann Arbor, contact: Thomas Horner, PhD, Child and Adolescent Psychiatric Hospital, University of Michigan Medical Center, Ann Arbor 48109 (313)764-5304.

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EMERGENCY MEDICINE For Emergency physician who possesses excellent clinical and trauma skills within a group of 7 emergency room physicians located in beautiful northwest Wisconsin area. Please send C.V. to: Dr. M. Jaghlit, 900 W. Clairemont Ave., Eau Claire, WI 54701, or call (715)839-4404.

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MEDICAL ONCOLOGIST: Central Wisconsin community of 50K needs aggressive Board eligible/Board certified physician with entrepreneurial skills to develop market of 200K with one other medical oncologist. Compensation/benefits package with minimum salary of $130K plus 100 percent of collections after expenses and office space. Contact Bob Sweat, Tyler & Company, 9040 Roswell Rd, Atlanta, GA 30350. Call 404/641-6411.

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FAMILY PRACTITIONER or internist. Full or part time. May be semi-retired for physicians office in the Southfield, Lathrup area. Call Richard Corey, Administrator (313)557-5155.

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PSYCHIATRISTS Physicians with training in general practice, family practice, or internal medicine, wanted to provide medical care to hospital psychiatric patients. Must be licensed in the State of Michigan. The Kalamazoo Regional Psychiatric Hospital is operated by the Michigan Dept. of Mental Health and is an EOE. Kalamazoo is located midway between Detroit and Chicago and is near Lake Michigan and many inland lakes. Salary is competitive with an excellent fringe benefit package. Inquiries should be directed to: Shaukat Jamal, MD, Acting Medical Director, 1312 Oakland Dr., Kalamazoo, MI 49008, phone 616/385-1344.

MONROE, MICHIGAN Seeking full-time emergency department physicians for 193-bed hospital located 30 miles south of Detroit. Approximately 23,000 patients seen annually. Must be Board eligible or board certified in primary specialty or emergency medicine. Excellent compensation and malpractice insurance provided. Benefit package available. Contact: Emergency Consultants, Inc., One Windemere Place, Room 23, Petoskey, MI 49770; 1-800-253-7092 or in Michigan 1-800-632-9650.

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Continued on next page

CLASSIFIEDS/Continued

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GENERAL SURGEON Board-certified general surgeon needed to join expanding, 85-physician multi-specialty medical center in Los Angeles and Orange counties. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to Box 117, *Michigan Medicine*, P.O. Box 950, East Lansing, 48826-0950.

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DEATHS/Continued

He was president of MSMS during 1968-69 and later served as a speaker of the Society's House of Delegates for nine years. He was active in the Wayne County Medical Society, serving as president in 1945-50. Doctor Lightbody edited the *Detroit Medical News* for 10 years and wrote a popular weekly column, *Rant and Rave.*

Ezra Lipkin, MD
Oak Park

Doctor Lipkin died November 10 at the age of 91. He graduated from the University of Michigan and the Detroit College of Medicine and Surgery. He retired 15 years ago from his medical practice on Michigan Avenue in Detroit. He was a founder of the North End Clinic in Detroit, where he worked for more than 25 years.

Rose Malach-Sexton, MD
Utica

Doctor Malach-Sexton, an ophthalmologist, died October 19 at the age of 49. She was a graduate of Wayne State University's medical school in 1965 and did her residency at the Kresge Eye Institute. Doctor Malach-Sexton was a member of the American Academy of Ophthalmologists, Michigan State Ophthalmological Society and the Macomb County Medical Society.

William O. Starbird, MD
Capac

Doctor Starbird, an obstetrician and gynecologist and former chief of the OB-GYN department at Detroit's Holy Cross Hospital, died October 16 at the age of 62. At Holy Cross, Doctor Starbird also was both secretary and treasurer of the medical staff and served on several committees. He was a member of the American College of Obstetrics and Gynecology, Macomb County Medical Society, National Board of Medical Examiners, American Board of Obstetrics and Gynecology, and the American College of Emergency Room Physicians. ☐

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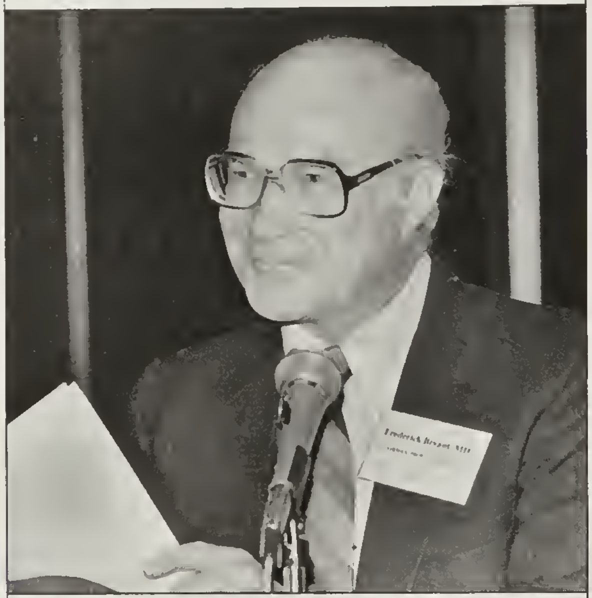
Smith Kline & French	71
Stratton-Cheeseman & Associates, Inc.	83
Upjohn	72
U.S. Air Force	95

AIDS: The battle is joined

By Frederick W. Bryant, MD

Editor's note: MSMS President Carl A. Gagliardi, MD, passed this month's President's Page to President-Elect Frederick W. Bryant, MD, who also serves as chairman of the AIDS Provider Education Task Force.


Frederick W. Bryant, MD

Virtually unknown and unheralded 'til the dawn of the '80s, AIDS has become everybody's concern within half a dozen years.

According to statistics published monthly by the Michigan Department of Public Health, 501 cases were diagnosed in the state by December, 1987, with precisely 300 deaths. This compares to 50,000 cases identified nationally and projections of five to ten million individuals affected worldwide.

Such figures serve as a convenient reference point in passing, but are outdated even as they are compiled. Michigan numbers are predicted to reach 3,000 to 4,000 three or four years hence.

For every person with classic AIDS, 80 to 100 others are seropositive (two to four million people in the United States). Fifty percent are expected to progress to clinical AIDS, and there is a real possibility that all, or nearly all, will eventually manifest the disease and succumb to it.

Costs are impressive and growing. Young individuals who have had little time to accumulate wealth, and little inclination to do so, are suddenly removed from productivity, perhaps to become wards of the State, reduced to contemplation of wasting, intercurrent complications, and death. AZT, a palliative but toxic drug costs $800 a month and may require transfusions every week or two. $150,000 has been quoted as the aggregate cost of caring for the average AIDS patient.

In fighting a disease of such high drama—hysteria, taboos, prejudices and mystery—with no immediate prospect of cure or immunological safety, education has emerged as a major rallying point. Knowledge tends to allay fear and point to sensible courses of action.

Early in the fray, MSMS, on its own, designed and distributed AIDS brochures, incorporated theme courses into its Annual Scientific Meeting and fostered cooperative programs with regional medical societies and auxiliaries.

With encouragement and support from government (the Governor's initiative, funding by the State Legislature, and conspicuously, from the State Health Department know-how and hard work), a coalition of 32 interested organizations collaborated to enunciate infectious disease control principles and gather a Speakers Bureau of 70-75 individuals. To date, those trained individuals have appeared on 163 occasions before 5,000 members of various health professions in an effort to inform them and particularly their leaders who may, in turn, act as information sources for their members and ultimately the public.

An informational phone line was opened to facilitate rapid resolution of problems and promote release of new information. MSMS serves in a leadership role in these efforts providing a library, phone line communications center, personnel and headquarters.

The battle is joined. To date, well over 100 countries have reported AIDS. Our nation and the world are alarmed and aroused. The enormity and severity of the problem dictate that we put in our best efforts and best people. A few of those involved speak to you in this issue of *Michigan Medicine*. ☐

See the improvement in the first week[1]

- **Sleep improvement in 74% of patients after first h.s. dose[2]**
- **Significantly faster relief–62% of total four-week improvement evident in first week versus 44% with amitriptyline alone[1]**
- **Dramatic first-week reduction in somatic complaints[2]**

% Reduction in Somatic Symptoms[2]

Vomiting	Nausea	Headache	Anorexia	Constipation
Reduced 90%	Reduced 86%	Reduced 72%	Reduced 62%	Reduced 60%

- **Only ⅓ the dropout rate due to side effects of amitriptyline alone, although the incidence of side effects is similar[1]**

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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References: 1. Feighner JP, *et al*: *Psychopharmacology 61* 217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc , Nutley, NJ

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses Myocardial infarction and stroke reported with use of this class of drugs) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e *g* , operating machinery, driving)

> ***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients Periodic liver function tests and blood counts are recommended during prolonged treatment Amitriptyline component may block action of guanethidine or similar antihypertensives When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive Discontinue several days before surgery Limit concomitant administration of ECT to essential treatment See Warnings for precautions about pregnancy Limbitrol should not be taken during the nursing period Not recommended in children under 12 In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects

Adverse Reactions: Most frequently reported are those associated with either component alone. drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs

Cardiovascular Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke

Psychiatric Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido

Neurologic Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns

Anticholinergic Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract

Allergic Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic. Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia

Gastrointestinal Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion

Other Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive I V administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning See complete product information for manifestation and treatment

Dosage: Individualize according to symptom severity and patient response Reduce to smallest effective dosage when satisfactory response is obtained Larger portion of daily dose may be taken at bedtime Single *h* s dose may suffice for some patients Lower dosages are recommended for the elderly Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12 5 mg amitriptyline (as the hydrochloride salt) Available in bottles of 100 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 50

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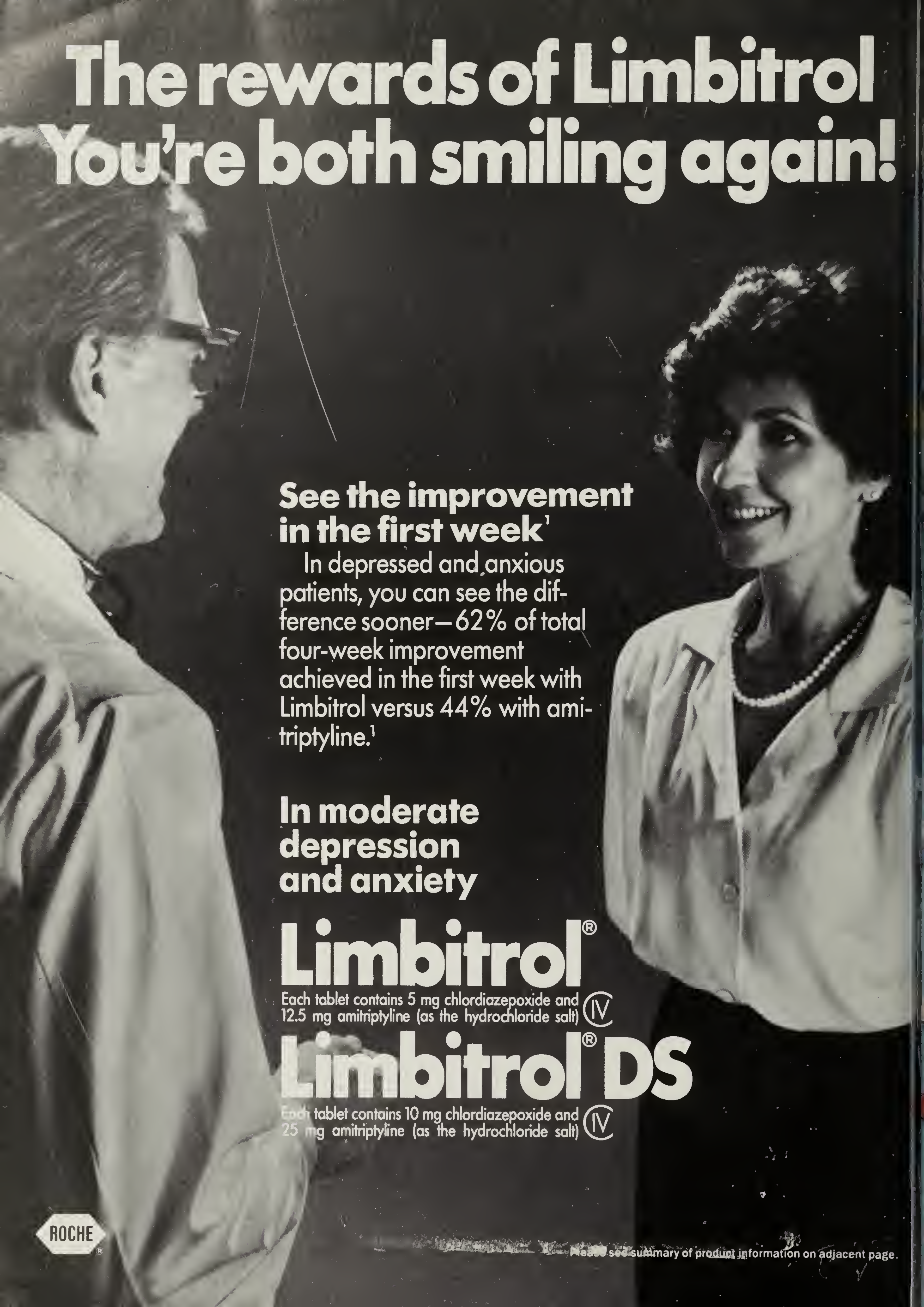

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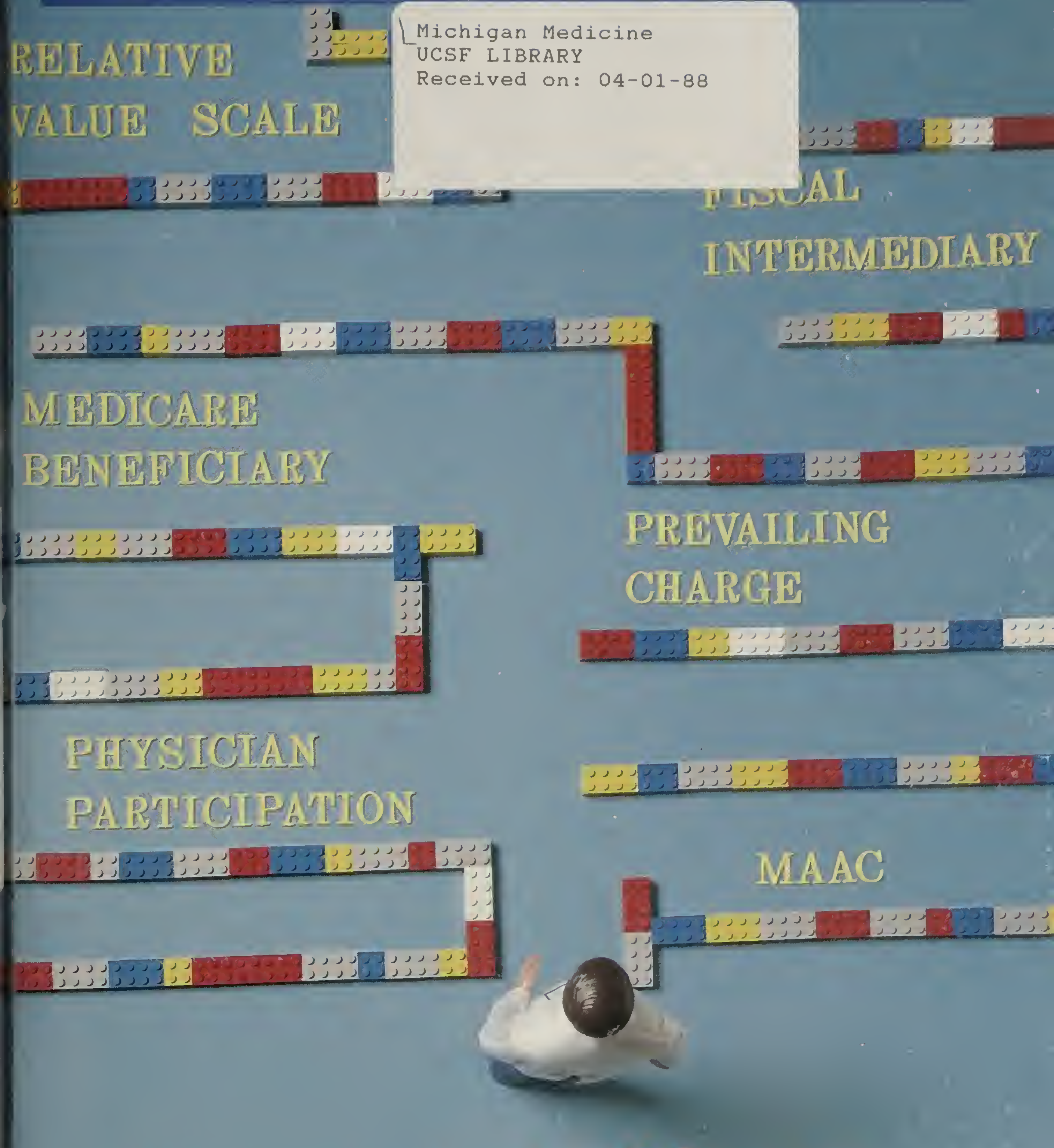

Making your way through the Medicare maze

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MICHIGAN MEDICINE

MARCH 1988 VOL. 87 NO. 3

Special Report

Medicare is a complicated and difficult health insurance program for physicians and patients alike to follow. In this month's special report, *Michigan Medicine* attempts to provide MSMS members with the information they need to successfully make their way through "the Medicare maze." Included in this month's special report is: a legislative summary by Bruce Blehart, JD, director of the AMA Department of Federal Legislation; a look ahead at Medicare's future, as seen by Ross Rubin, JD, director of the AMA Division of Legislative Activities; and a personal look at how one MSMS member handles his relationship with Medicare. 114

Features

MSMS Special House of Delegates highlights
A photo feature 122

Treatment withdrawal in Michigan courts
A look at a recent court ruling regarding treatment refusal and withdrawal and its implications for Michigan physicians — By Howard Brody, MD 126

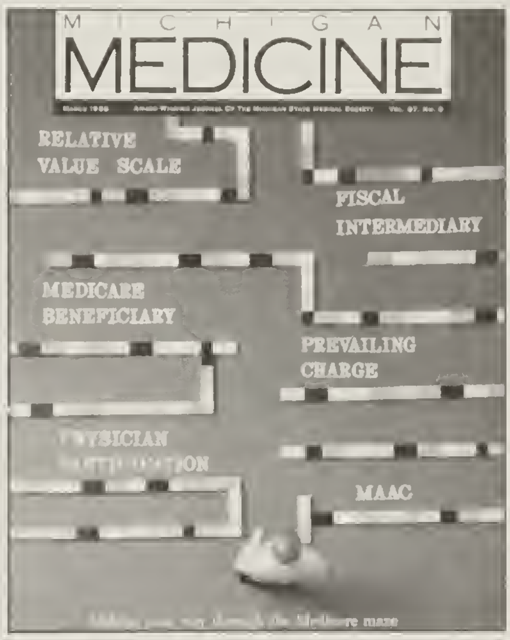
Recommendations for physician office laboratories
The Michigan Department of Public Health offers a variety of recommendations to help improve the quality of physician office lab operations — By James T. Sgouris, DO, PhD 136

AIDS update 141

School workplace wellness
It is possible for school-based employees to lead healthy lifestyles and for schools to foster healthy climates for students — with physician support! — By Rick Murdock 144

Handling insurance company requests for patient information
MSMS legal counsel offers physicians advice in *Michigan Medicine's* new legal column — By Richard D. Weber 146

Medical students win AMA member contest
A photo feature 150



Departments

In my opinion
"Land of the free," "All men are created equal"... Really?
By Henry M. Domzalski, MD 112
Letters 113
Physicians in the news 156
Deaths 158
Category I courses 177
Meetings 179
Classified 181
Ad index 183
President's page
Take the lead in Medicare change
By Carl A. Gagliardi, MD 184

In next month's issue of *Michigan Medicine:* A look at the people who make MSMS what it is today, plus other news updates in the new MSMS annual report.

Cover photo by Kim Kauffman.

IN MY OPINION

"Land of the free," "All men are created equal" . . .*Really?*

By Henry M. Domzalski, MD

In this country the National Anthem is vigorously sung prior to many events such as athletic contests. We hear, over and over again, the words "land of the free."

Recent developments have led me to pause and reflect.

Federal involvement in health care, on a grand scale, began in 1966 with passage of the Medicare Law and Title XIX.

Initially, there was a barely perceptible erosion of freedoms we physicians had known. The trickle has now become a monstrous torrent. One bureaucratic directive seems to be followed in short time by another, even more demeaning, unilateral directive.

Henry M. Domzalski, MD

We had almost learned to live with MAACs, with having names of participating physicians published in a "preferred directory," with variability of honoring claims made by participating physicians versus those of nonparticipating physicians, with reimbursement differentials, etc.

And now comes the latest. Federal Law effective October 1, 1987 mandates that if a nonpartipating physician collects *an* amount from a patient as full o partial payment for non-covere services, the amount must be refunded to the patient within 3 days of notification by Medicare Furthermore, a physician wh does not comply with said directive *can* be fined thousands o dollars! This is regardless of circumstances.

A patient *may* pay for a servic he or she wants if a "waiver" titled "Medically unnecessary release" is signed before treatmen and kept on file! What an untenable position to find onself in What wonderful PR.

"Land of the free!" Really?

That's my opinion. You probably have your own opinions.

In the following pages, *Mich*

Continued on page 15

Doctor Domzalski is the current chairman of the MSMS Committee on Publications.

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The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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A sad commentary indeed

Editor's note: In the January issue of *Michigan Medicine* John Hall, MD, a member of the MSMS Committee on Publications and of the MSMS Board of Directors, expressed his disappointment over Ameritech's refusal to include a first aid guide, called *LifeGuide*, in its phone book out of fear of being sued. In his article, which appeared on *Michigan Medicine's* "In My Opinion" page, Doctor Hall wrote: "It is a sad commentary on our society and the dominant role that liability is playing on it. A valuable guide and potential lifesaving public service has been lost." Below is a response to his article.

In the interest of time and because of my own busy schedule, I simply want to congratulate you (Doctor Hall) on your statement in *Michigan Medicine.* You are so right, "It is a sad commentary!"

My warmest regards to you.

George W. Morley, MD
President
The American College of
Obstetricians & Gynecologists

Reyes Syndrome update

In the period from October 1, 1986 to September 30, 1987 two cases of Reye's Syndrome were

Continued on page 131

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SPECIAL REPORT

Getting through the Medicare maze

By James G. O'Brien, MD

Doctor O'Brien

Medicare—the very name conjures feelings of confusion.

The federal health insurance program is complicated and difficult for physicians and patients alike to follow. It is like shifting sands with constantly changing patterns.

The changes are likely to continue, for with every year's budget planning, Congress initiates new Medicare features.

The changes are accelerating lately, too, as Medicare expenses grow with an expanding senior population, and as the government seeks more ways to rein in costs.

With this month's special report, *Michigan Medicine* seeks to help MSMS members comprehend the most recent Medicare changes.

The study of Medicare and its interpretation for members come under the purview of the MSMS Committee on Aging, which serves primarily as a conduit of information about the federal program.

MSMS is pleased to present this month's *Michigan Medicine* special report. In these pages you will find:

1) A summary by Bruce Blehart, JD, director, AMA Division of Legislative Activities, of the highlights of the Omnibus Budget Reconciliation Act of 1987. The reconciliation process occurs each year and represents an attempt by Congress to adjust the funds spent and to balance the federal budget.

Mr. Blehart has highlighted some key provisions which regulate payment for physician services.

All portions of the 1987 Ac which regulate payments to hospitals and physicians under Medicare Parts A and B cannot b printed in *Michigan Medicine* They are too lengthy and complicated for these spaces.

Omitted portions which do no appear in these pages affect incentive payments for physicia services in underserved areas payment for anesthesia services fee schedules for radiology an pathology services, clinical mental health services, and vaccin compensation.

MSMS members who woul like the details of these feature of the Act may contact Mr. Blehart at the AMA. His telephon number is 312/645-4764.

2) A look ahead at Medicare' future, as seen by Ross Rubin JD, director, AMA Departmen of Federal Legislation.

3) A personal look at how on MSMS member handles his Medicare relationship. George C Whitaker, MD, a Kalamazo ophthalmologist, deals daily wit the federal health insuranc program.

On behalf of all the member of the Committee on Aging, hope that these articles will hel our fellow MSMS members better navigate the Medicare maze If you have further questions o comments after reading thes pages, please contact Tom Whit at MSMS headquarters.

Doctor O'Brien is chairman of the MSMS Committee on Aging, and is the director of Programs on Aging, College of Human Medicine, Michigan State University.

Highlights of the 1987 Omnibus Budget Reconciliation Act

By Bruce Blehart, JD

Payment freezes

Three-month freeze

During the three-month period nding on March 31, 1988 pre-ailing and customary charge evels will be maintained at the evels in effect during 1987. Max-mum Allowable Actual Charges MAAC) for individual physi-ians' services furnished by non-participating physicians during he three-month period ending on March 31, 1988 will be the mount determined for 1987. 1988 MAACs will go into effect on April 1, 1988.)

Physician participation agreements

Physicians who were partici-pating physicians in 1987 were allowed to terminate their 1987 agreement if they requested to do o prior to December 31, 1987. Otherwise, all agreements in ef-ect on December 31, 1987 re-main in effect for the three-month period ending on March 31, 1988. The effective period for participation agreements entered nto for 1988 will be the nine-month period beginning on April 1, 1988. An opportunity for phy-icians to enroll or disenroll as participating physicians will be provided by the Secretary prior o April 1, 1988.

Directories of participating physicians for 1988 will be pub-ished at the beginning of the nine-month period beginning on April 1, 1988. Non participating physicians will be provided a list of MAACS for 1988 at the beginning of the nine-month period beginning on April 1, 1988.

Payment update

Increase in Medicare Economic Index (MEI)

For services provided by participating physicians after March 31, 1988, the percentage increase in the MEI is 3.6 percent for primary care services and one percent for other physicians' services. Increases for the services of non-participating physicians during this period will be 0.5 percent less than the increase allowed participating physicians (3.1 percent and 0.5 percent). For physicians' services furnished in 1989, the percentage increase for participating physicians is to be three percent for primary care services and one percent for the physicians' services. The increase in 1989 for non-participating physicians will be 0.5 percent less (2.5 percent and 0.5 percent). By January 1, 1989 the prevailing charge differential between non-participating and participating physicians will be five percent.

Primary care services

"Primary care services" are defined to mean the following physicians' services: office medical services (HCPCS Codes 90000-90080); emergency department services (Code 90500-90570); home medical services (Codes 90100-90170); skilled nursing, intermediate care, and long-term care medical services (Code 90300-90370): or nursing home, boarding home, domiciliary, or custodial care medical services (Codes 90400-90470).

Application of MAAC

Monitoring

The Secretary will be authorized to monitor the actual charges of each non-participating physician. Where a physician knowingly and willfully bills on a repeated basis for a service and actual charge in excess of the MAAC, the Secretary will be authorized to apply sanction. This provision is effective for services provided after March 31, 1988.

Adjustment

Where a physician who did not have actual charges under Medicare for a procedure during the period of April through June 1984 can demonstrate to the satisfaction of the carrier that he or she had actual charges for the procedure at any time prior to June 30, 1984, the carrier is to compute a MAAC for 1988 based on the physician's actual charges for the procedure.

Over-priced procedures

Reductions

The following physicians' ser-

Continued on next page

The author is director of the AMA Department of Federal Legislation.

vices provided after March 31, 1988 will be subject to specific "reasonable charge" reductions: bronchoscopy (Codes 31622-31626), carpal tunnel repair (Code 64721), cataract surgery (Codes 66830-66985), coronary artery bypass surgery (Codes 33510-33528), diagnostic and/or therapeutic dilation and curettage (Code 58120), knee arthroscopy (Codes 29880-29881), knee arthroplasty (Code 27446-27447), pacemaker implantation (Code 33206-33208), total hip replacement (Codes 27130-27132), suprapubic prostatectomy (Code 55281), transuretheral resection of the prostate (Code 52601), and upper gastrointestinal endoscopy (Codes 43235-43239).

After March 31, 1988, the 1987 prevailing charge levels for these services initially will be reduced by two percent. Further reductions of up to 15 percent will be implemented according to a sliding scale formula.

Prevailing charge levels that are at or above 150 percent of the weighted national average of prevailing charges for the procedure in all localities in the US for 1987 will be reduced by 15 percent. Where the physician's prevailing charge level for the service does not exceed 85 percent of the weighted national average, there will be no reduction beyond the two percent previously described. Where prevailing charge levels are between 85 percent and 150 percent of the weighted national average, the percentage reduction will be based on a straight-line sliding scale equal to three thirteenths of a percentage point for each percent by which the prevailing charge exceeds 85 percent of the weighted national average.

Charge limitations

Where a non-participating physician's allowed charge is reduced pursuant to the application of "inherent reasonableness," this provision, cataract procedures (OBRA), or physician supervision of certified registered nurse-anesthetists (CRNA), the physician may not charge the beneficiary more than 125 percent of the reduced allowed amount plus one-half of the amount by which the physician's MAAC for the service for the previous 12-month period exceeds the 125 percent level. This provision will be applicable for the 12-month period after application of "inherent reasonableness" authority, and during the nine-month period following application of the reduction authorized by this provision. In subsequent years, the maximum allowed charge will be set at 125 percent of the prevailing charge level. Where a physician "knowingly and willfully" imposes a charge in violation of this provision, the Secretary is authorized to apply sanctions against the physician (civil monetary penalties, assessments, and five-year barring).

These charge reductions will not apply to services furnished after the earlier of December 31 1990 or one year after the Secretary reports to Congress on th development of the RVS. (Th two percent special reductio scheduled to go into effect fo cataract surgical procedures pursuant to OBRA-1986 is repealed and the 1987 reduction implemented by OBRA stays in effec until March 31, 1988).

Customary charges for services of new physicians

In determining the customar charge levels for physicians' services where a physician does no have adequate actual charge dat due to the physician not havin been in practice for a sufficien period of time, the Secretary wil set a customary charge at a leve no higher than 80 percent of th prevailing charge for the servic in the area. This limitation wil not be applicable for primar care services (previously defined or for other services furnished i a rural area designated as health manpower shortage area This provision will be effectiv for physicians who first furnis services to Medicare beneficiarie after April 1, 1988.

Diagnostic lab tests

Fee schedules and payment limit

For tests provided during th three-month period endin March 31, 1988 no charge in th fee schedules for clinical laboratory diagnostic tests will be effec tive. In determining revised fe

hedules for 1988, the Secretary
not to adjust the fee schedule
take into account any increase
the CPI.

Effective for services provided
ter March 31, 1988, fee sched-
les for automated tests and for
sts (other than cytopathology
sts) that were subject to the
west charge provision (HCPCS
odes 80002-80019) prior to
mpletion of the clinical labora-
ry fee schedule in 1984 will be
duced by 8.3 percent. The limi-
tion amount for payment for
boratory tests will be main-
ined at 115 percent of the me-
ian of all fee schedules through
arch 31, 1988. After that date, the limitation amount will be equal to the 100 percent of the national median of all of the fee schedules established for that test.

Physician office labs

Physician's office laboratories that have a volume of total clinical diagnostic laboratory tests in excess of 5,000 per year will no longer be included in the physicians' office exclusion for certification of clinical laboratories. (To qualify for Medicare reimbursement, these laboratories will have to meet the same Medicare conditions for coverage that apply to independent laboratories.) This provision will be for diagnostic tests performed on or after January 1, 1990.

Penalties

Individuals who knowingly and willfully, and on a repeated basis bill beneficiaries for charges for clinical diagnostic laboratory tests on an unassigned basis, will be subject to sanctions. This provision is effective on January 1, 1988. The moratorium for conducting demonstration projects on competitive bidding for clinical laboratory services will be extended through January 1, 1989.

The future of Medicare

By Ross N. Rubin, JD

This article will discuss the en-
ronment that could lead to ma-
r structural reforms in physi-
an reimbursement and reim-
ursement methodologies in
overnmental and private sector
ealth benefit plans.

Congress and the private sec-
r are both concerned about in-
eases in total costs for physician
rvices. Until recently, the pri-
ary concern about the cost of
edical care has focused on the
ossible bankruptcy of the Medi-
are Part A trust fund (relating
institutional services). Cost control methods focused primarily on institutional services and physician services provided in institutions.

These very trends in the hospital area have, however, created increased pressures to deal with costs in the physician services area. Many programs initiated in the hospital sector were designed to reduce hospital costs by transferring services out of the "expensive and inefficient" hospital into the outpatient setting. Medicare has specifically encouraged this trend, for example, by providing for specialized reimbursement for outpatient surgicenters, special reimbursement for physicians performing surgery on an outpatient basis, and outpatient rehabilitation services costs. The diagnostic-related grouping (DRG) system for reimbursing hospitals continues the trend to move services away from the hospital and into the physicians' services sector.

As a result of these trends, along with the increased number and age of Medicare beneficiaries, costs have rapidly escalated in the "physicians" service sector. During the period 1980-1983, payments for physicians' services under Medicare have increased at an annual rate of 20.4 percent. During the same period, general

Continued on next page

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revenue contributions to the Part B trust fund have increased at an annual rate of 28.2 percent from $6.6 billion in 1980 to $14 billion in 1984.

It is obvious that these increases in cost have caught the eye of Congress in light of efforts to cut budget expenses and to reduce the federal deficit. What also has caught the attention of Congress is that total physicians' services costs are increasing in the Medicare program, and beneficiaries are being exposed to increased out-of-pocket expenditures for physicians' services. For the short-term, this concern has manifested itself in Congressional action to freeze and then control charges and fees of physicians under the Medicare program, place special limits on certain so-called overreimbursed procedures, mandate assignment on clinical laboratory services, and require the study of various major modifications to the system for physician reimbursement including DRGs for physicians and a major initiative toward a relative value study.

Structural issues

We have come a long way from traditional fee-for-service and usual, customary, and reasonable as the principal ways of paying for physicians' services. Traditional fee-for-service is also being targeted for change. Capitation, salaried arrangements, and incentive plans are all changing the structural basis for how we pay for physician services. To understand why there is so much concern regarding the current system, it is important to discuss some of the structural problems that are perceived in fee-for-service and usual, customary, and reasonable (UCR) as encouraging the delivery of high-cost, high-technology medical care. These perceived defects include the following items.

> **"We have come a long way from traditional fee-for-service and usual, customary, and reasonable as the principal ways of paying for physicians' services. Traditional fee-for-service is also being targeted for change."**

1. Specialists are often reimbursed for services at a higher rate than nonspecialists, regardless of whether there is a need for specialized knowledge in the delivery of the services. This defect is thought to encourage increased specialization by physicians and also increase costs for health benefit plans beyond what is necessary for quality medical care
2. By reimbursing for services at a higher rate in urban areas, current systems encourage practitioners to locate in those areas even if there is already an abundance or overabundance of physicians. Therefore, instead of competitive and crowded market conditions lowering prices, the bias toward urban areas keeps prices high even though there is no general scarcity.
3. Under current reimbursement practices, reimbursement levels do not fall when a procedure becomes common, involves less risk and resources.
4. The very system of fee-for-service, whereby one is rewarded for providing more services, appears to be in conflict with the delivery of cost-effective care.

That is not to say that proposed solutions to these problems do not raise concerns of equal gravity.

1. Who is the advocate and ombudsman for the patient when incentive plans reward the physician for providing the minimally acceptable amount of care?
2. As the population ages and technology improves, will we have the right set of incentives to assure that there will be an adequate pool of specialists?
3. Will there be appropriate incentives to assure that technology advances at an appropriate rate to benefit patients, or will inertia set in delaying new developments because of reimbursement biases?
4. Do alternative systems encourage the right amount of risk-

Continued on page 120

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taking that is necessary to advance the state of the art?

Relative value study

It is clear that we are moving toward change in the reimbursement area. The questions that need to be raised relate to whether we are moving in a manner that truly addresses the concerns discussed. Can a balance be set? Can the consumer be better informed? Is it possible to have a system that rationally looks at the available data so that objective determinations can be made? Is it possible to place some self-correcting mechanism that allows all the parties involved to accept the system as reasonable? The answer to these questions is affirmative.

The ability to obtain and use data is now greater than at any prior period of time. Universal coding systems, such as CPT-4 and HCPCS, are now enhancing our ability to review objectively what is being done and how it is being paid for. We now can compare data from region to region and see if there are major differences that need to be explored.

The American Medical Association is currently working with Harvard University on the development of a relative value study (RVS) to establish resource cost-based relative values for physicians' services. This study, funded by the Health Care Financing Administration, is scheduled for completion in July 1988. An *indemnity* reimbursement system founded on a resource cost-based relative value study could ameliorate many of the uncertainties inherent in the current Medicare reimbursement scheme. It would provide patients with a greater understanding of charges made for each service. It would also address inequities in payment rates for services that are built into the current method of reimbursement. It would provide predictability for third party payors, both public and private.

> **"The current environment of concern about . . . the structural validity of current reimbursement practices for physicians' services sets the stage for major efforts towards modifying and 'reforming' the way physicians' services are paid for."**

Pending the development of the resource cost-based RVS, the Medicare physician reimbursement methodology could be changed to an indemnity system based on historical charge levels with proper adjustments for geographical variations in practice costs and annual inflation updates. Such a change would be a appropriate interim measure tha would have the advantages c eliminating confusing elements c the current "customary, prevai ing, and reasonable" paymen system and providing more pre dictability through an indemnit reimbursement schedule. Saving also would accrue from such change, as carriers would n longer have to maintain extensiv physician fee profiles. The pre dictability of the reimbursemen amount could even engender higher assignment rate under th Medicare program.

Conclusion

The current environment o concern about rising physicians services costs to health benefi programs (and their effect on federal budget deficits and labo costs in the private sector), increased out-of-pocket expenditures for certain beneficiaries and the structural validity of current reimbursement practices fo physicians' services sets the stag for major efforts towards modifying and "reforming" the way physicians' services are paid for While this article has focused o Medicare, the efforts will b closely monitored by the privat sector in determining how t meet its goals of moderating increases in the costs of physicians service.

Changes in the system must b made in a rational manner to ensure that, in the long term, th health and safety of the sick ar not jeopardized. ☐

Kalamazoo Ophthalmologist battles Medicare woes

By Betty J. McNerney, Managing Editor

F or many doctors, the very ention of Medicare conjures elings of confusion. After all, it a complicated and difficult ealth insurance program to fol- w. More importantly, its fea- ires are constantly changing, nd of late, very rapidly.

For George Whitaker, MD, a alamazoo ophthalmologist, this onstant state of flux has made his fe quite unsettling, especially nce more than 90 percent of his atients are on Medicare.

“I never know what is going to appen next,” says Doctor Whit- ker. “Every year there are major hanges (in Medicare reimburse- ent policies). In the last two ears, there has been a 25 percent eduction in reimbursement for ataract surgery.”

“Because Medicare reimburse- ent policies change so fre- uently,” Doctor Whitaker said, t is difficult to plan my life for ore than six months at a time. ext year is a total unknown.”

oor communications ompound problem

As if the constant changes in eimbursement policies aren't ad enough, Doctor Whitaker id poor communications be- veen Medicare and his office in- nsify his confusion.

“Medicare informs me of pol- y changes in the form of a let- r,” says Doctor Whitaker. Sometimes it is not easy to inter- ret what the letter is actually ying. While I might call Medi- are for help, it is often difficult to get through to someone there and when I do, they aren't always helpful.”

Doctor Whitaker said he has “never seen any explanation of Medicare policies from Medicare. I should have a phone number and an assigned representative I can call for help,” he said.

Doctor Whitaker says when he does have a question about Medicare he usually calls MSMS and other professional groups of which he is a member.

Medicare patients equally confused

As for his patients, Doctor Whitaker says they are equally confused about Medicare policies. “I really don't know how they (my patients) are informed about Medicare changes,” he said.

What can be done?

To help alleviate some of the frustration and confusion Doctor Whitaker experiences, he corresponds regularly with his local congressman about issues specific to ophthalmology and medicine in general.

“I write letters about every six months and I usually get letters back,” Doctor Whitaker said. “While I don't think they (congressmen) understand the issues surrounding Medicare, I do think they are sincere. Over the long haul, I think my letter writing does make an impact. It is worthwhile.”

Even more effective than letter writing, says Doctor Whitaker, would be for all doctors to “attempt to mobilize their patients,” to educate them about the problems with Medicare. “They could serve as a very powerful force at voting time.” ☐

> “I never know what is going to happen next. Every year there are major changes in Medicare reimbursement policies. In the last two years, there has been a 25 percent reduction in reimbursement for cataract surgery.”

A new source of Medicare clarification available

The AMA has produced a 20-minute video on Medicare, copies of which are for sale. For details, contact Deborah Zannoth at MSMS.

MSMS Special House of Delegates highlights

Senator John "Joe" Schwarz, MD, right, talked with MSMS State Legislation and Regulations Committee Chairman Frederick V. Minkow, MD, before speaking to the delegates.

Harold D. Portnoy, MD, a Bloomfield Hills neurosurgeon, was amor the first physicians to testify at the single-issue special House sessio

Photos by Pattrick Yockey
More on page 124

One hundred thirty-two MSMS delegates Jan. 30 in Lansing approved further study and negotiation of the proposed State Medical Liability Trust.

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MSMS President Carl A. Gagliardi, MD, called the special meeting a "crucial time in the history of MSMS." He urged the delegates to support the Board's "modest recommendation" for further study of the Trust proposal. "Give the Board the authority to carry out your wishes," he said.

Speaker of the House Gerald H. Mandell, MD, left, and Vice Speaker Robert D. Burton, MD presided over the introductions, addresses, delegates' remarks, and finally, the vote, which wa carried out by raised hands.

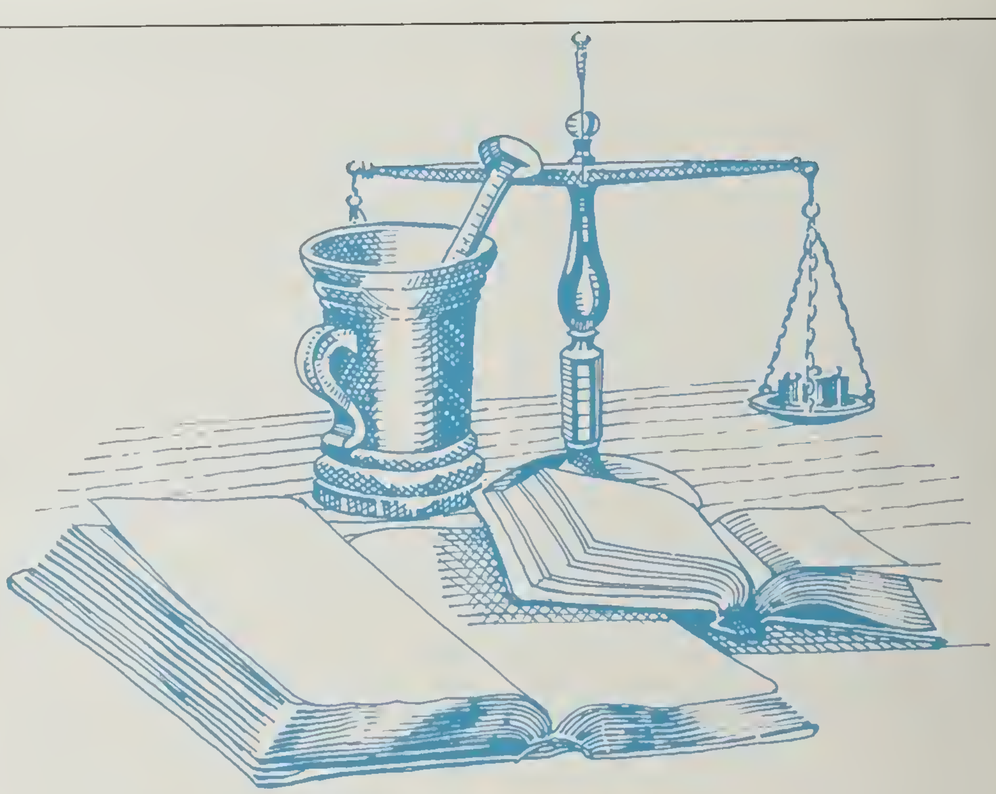
MSMS Board Members B. David Wilson, MD, Kalamazoo, left, and Jack L. Barry, MD, consulted background materials as nearly 30 delegates testified about provisions of the proposed Trust.

MSMS Board Chairman Robert E. Paxton, MD, emphasized the long-range MSMS goal remains the search for alternatives to the tort system for solving liability disputes. The most important thing, he said, is unity. "We won't get anywhere without it."

Tom Nixon, Physicians Insurance Company of Michigan, left, and Jacque Sammet, Michigan Hospital Association, consulted notes during the three-hour meeting. The majority who spoke disapproved of features of the Trust, yet all but a few delegates approved their Board's recommendation for further study and negotiation of the Trust proposal.

The Culham Decision: treatment withdrawal in Mich.

By Howard Brody, MD



Since the Karen Quinlan case 12 years ago, many state courts have ruled on termination of life-prolonging medical treatment. Moreover, at least 39 states have passed advance directive statutes, laying down guidelines for making wishes known now to facilitate medical decisions later.

As Michigan has had neither a court decision nor a statute, many have felt that the legal status of treatment refusal and withdrawal in Michigan is particularly troublesome. In this setting, any decision from a Michigan court is both important and informative.

Such a decision came from Judge David F. Breck of the Oakland County Circuit Court on December 15, 1987, in response to the petition of Clifford Culham. This article will review the case, the court order, and possible implications for Michigan physicians.

The facts of the case

Clifford Culham was diagnosed with amyotrophic lateral sclerosis in 1983, at age 53. In April, 1986, he developed respiratory failure and began treatment with a ventilator and a feeding tube. He was cared for for some time at home, but for reasons of family exhaustion and insurance coverage, he had to be moved to a nursing home in Ohio. When the hearing was held, Culham was paralyzed except for the ability to shake his head and to point with one hand.

In 1985, Culham had executed a durable power of attorney, naming his wife as agent to make medical decisions in the event he was incapacitated, and specifically empowering her to remove the ventilator and feeding tube. In 1987, he requested that life-sustaining treatment be stopped. He had a sympathetic physician in Doctor Mark Glassberg, a neurologist specializing in ALS cases. However, the hospital to which Mr. Culham would have been moved objected and insisted on a court order. This began the process of the petition to the circuit court in Oakland County, Culham's legal residence.

Culham's attorney, David M. McCleary, obtained excellent advice from national "right to die" organizations, and accordingly his petition included references to very recent documents such as the "*Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*" (Hastings Center, New York, 1987), and recent New Jersey court decisions.

Ultimately the hospital dropped out of the case when it was decided that treatment withdrawal could occur in the patient's home under Doctor Glassberg's supervision.

Culham's family unanimously supported his choice, and other organizations, including the Attorney General's office, refused to get involved; hence the petition was uncontested. Later it was reported that a local Right to Life attorney had followed the case but had no disagreement with the proceedings.

Two psychologists certified that Culham was fully-rational and competent.

Judge Breck held a special fact-

Continued on page 132

Doctor Brody is a member of the MSMS Committee on Bioethics and is an associate professor, Medical Humanities Program, Michigan State University.

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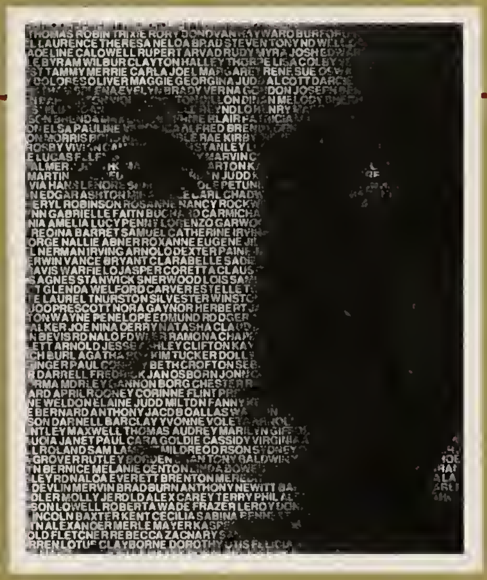

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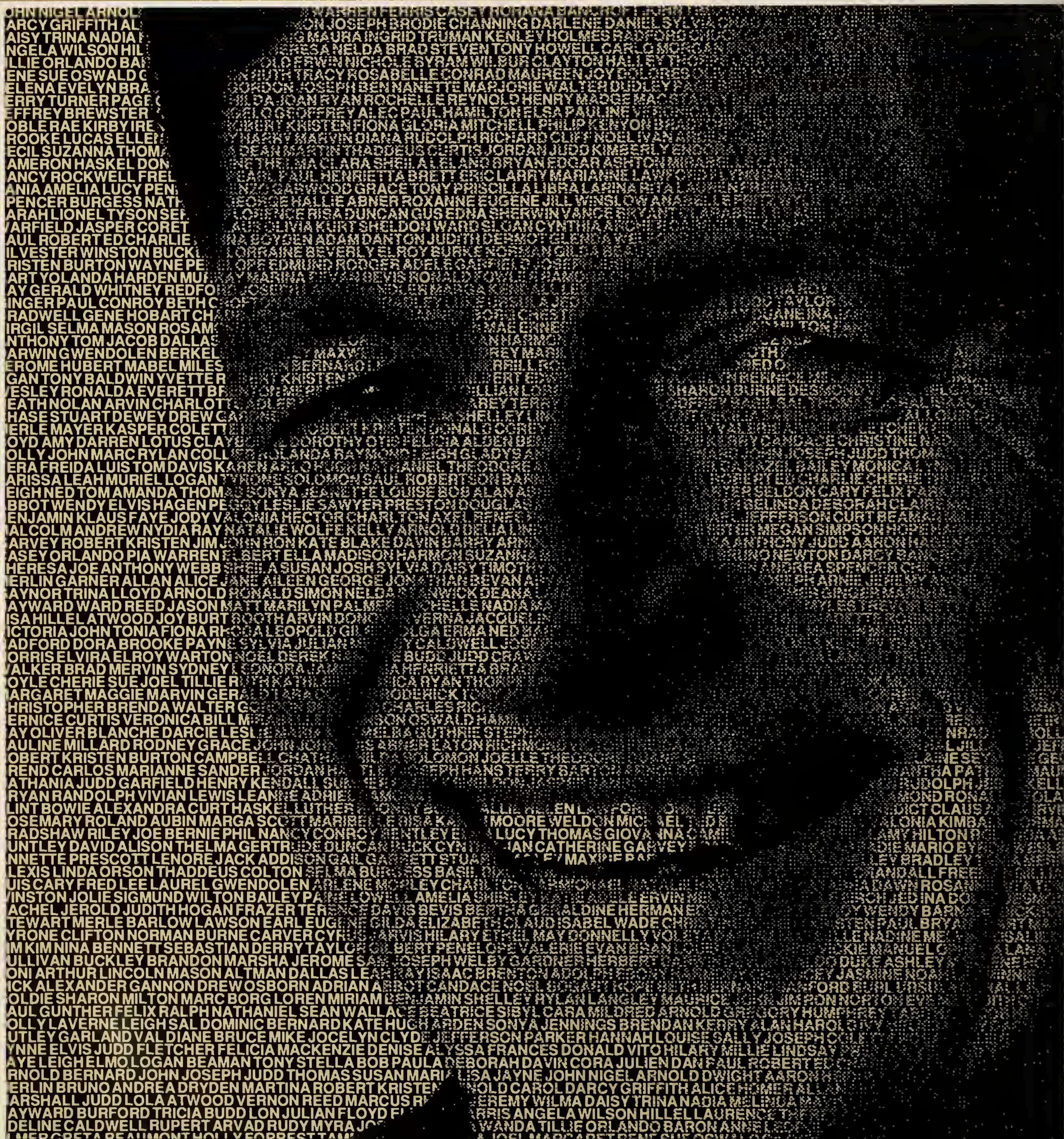

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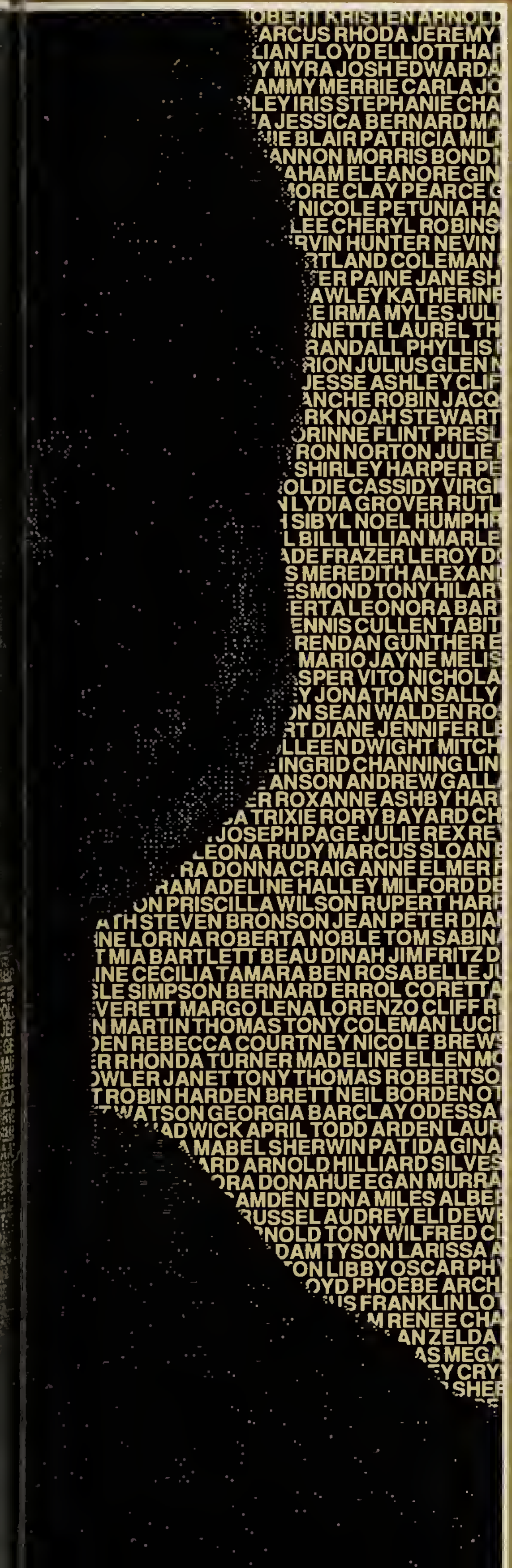

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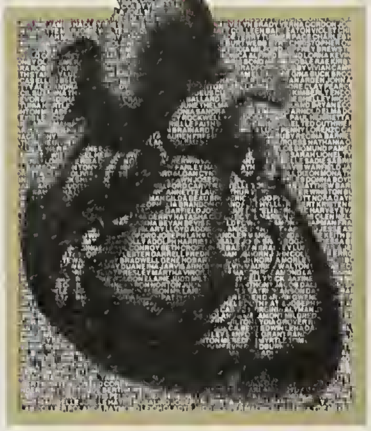

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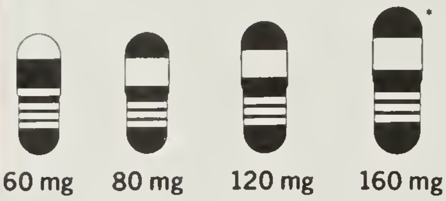

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INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. There abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyr ism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been report which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a de pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impa hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hype sive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a retur increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL (propranolol HCl) is administered. The ad catecholamine-blocking action may produce an excessive reduction of resting sympath nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal atta or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calc channel-blocking drug, especially intravenous verapamil, for both agents may depress myoca contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use beta blocker and verapamil has resulted in serious adverse reactions, especially in patients severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, *phenobarbitone*, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma leve both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increa blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in ani have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant dru duced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Repro tive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in an studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have r required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypoten paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassi weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; h cinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased pe mance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dre appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, cons tion, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence. Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the serous membranes and conjunctivae reported for a beta blocker (practolol) have not been assoc with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily. If patients are switched from INDE Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic eff maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDE INDERAL LA has different kinetics and produces lower blood levels. Retitration may be neces especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg daily or higher until adequate blood pressure control is achieved. The usual maintenance dosa 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time neede full hypertensive response to a given dosage is variable and may range from a few days to se weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once dosage should be gradually increased at three- to seven-day intervals until optimal respon obtained. Although individual patients may respond at any dosage level, the average optimal do appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 32 per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradua achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four t weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It ma advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limi permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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ETTERS/Continued

eported to the Michigan Depart-
ent of Public Health (MDPH).
ne case was a three-year-old
ale from Macomb County, who
ied in November of 1986. The
econd reported case was a
velve-year-old female from
linton County. Neither case sat-
fied the Centers for Disease
ontrol case definition.

This is the final edition of our
pecial surveillance updates. We
o longer request that you phone suspected cases of Reye's Syndrome directly to the Disease Surveillance Section of the MDPH. Reye's Syndrome is a legally reportable disease in Michigan, so any diagnosed case should still be reported to the appropriate county health department.

We appreciate very much your conscientious efforts, which made our special surveillance successful. We are very pleased to see the precipitous drop in the incidence of Reye's Syndrome and hope we will see this low incidence continue. Thank you again for your cooperation and assistance during this special surveillance effort.

William N. Hall, MD
Harry McGee, MPH
Disease Surveillance
Michigan Department of
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finding hearing at the patient's nursing home bedside and came to the same conclusion.

The court decision

Judge Breck reviewed both the above facts and also the testimony of an expert witness on medical ethics (this author) whom he had appointed for assistance. He ordered that Doctor Glassberg could comply with Culham's request for treatment withdrawal without fear of civil or criminal liability.

The opinion noted the unanimous agreement of widely-quoted reports on medical ethics, and judicial opinions in several other states, on the right of a competent patient to refuse medical treatment. It follows most closely the reasoning of Farrell (NJ, 1987), which also involved removal of a respirator from an ALS patient at her request. The Farrell method was, basically, to determine first that a patient is competent, informed of the consequences, and deciding voluntarily.

Next the court considered four possible state interests in prolonging life: preservation of life; preventing suicide; safeguarding the medical profession; and protecting innocent third parties.

The conclusion was that in Farrell's (and in Culham's) case, the constitutional right to privacy or self-determination clearly outweighed these four state interests. Judge Breck ruled specifically that following Culham's wishes would not constitute either suicide or homicide.

Implications for physicians

The Culham decision is a lower-court ruling, unlikely to be appealed, and hence sets no legal precedent, though other Michigan judges may find it persuasive. Michigan physicians faced with difficult cases should seek qualified legal advice for their own information. However, I believe it is possible to draw some lessons from this first Michigan ruling on a commonly encountered, but emotional, topic.

First, it is notable that the first Michigan court to face such an issue drew on the same sorts of guidelines and reports as have the high courts in many other states. The competent patient's right to refusal; the equating of artificially administered food and fluids with other forms of medical treatment; and the refusal to label death by treatment refusal as suicide or homicide all follow prevalent national trends and the most widely-accepted views in medical ethics (including the AMA's guidelines).

Second, the court can be seen as indirectly endorsing durable power of attorney as a mechanism for advance directives. The court noted that Culham was now competent, and hence his 1985 document naming his wife as his agent need not come into force.

But Judge Breck went on to note that if Culham should later become incompetent, treatment withdrawal might still proceed because of the "unimpeachable evidence of Mr. Culham's competent desires." (One bill now before the Michigan legislature, sponsored by Rep. David C. Hollister, (D-Lansing) recognizes durable power of attorney as the primary legal basis for advance directives for medical treatment.)

Third, the case was ethically straightforward and unambiguous, leaving us little idea of how a Michigan court would handle a messier case. For instance, no family member objected to carrying out Culham's wishes; physicians seem to fear treatment removal most especially in cases where one or more of the family members disagree and threaten legal action. Still, the *logic* of the ruling makes it clear that family unanimity is *not* an essential precondition for carrying out the patient's own competent wishes and Judge Breck has informally commented that he would so rule, should such a case come before him.

Fourth, the judgment makes it clear that removing a respirator from a living patient is not against the law in Michigan. The 1975 Michigan statute on determining death contains one sentence which states that brain death will be pronounced before artificial life support is withdrawn.

Continued on page 134

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TREATMENT WITHDRAWAL/Continued

Knowledgeable and practical legal thinkers read this sentence in the context of the entire law, as applying *only* to brain-dead patients and as simply specifying the correct sequence of events for the medical record. However, some hospital attorneys have taken this sentence totally out of context and suggested that Michigan law opposes removing a respirator from any patient who is not brain dead. Clearly Judge Breck disagrees with this interpretation.

Always go to court?

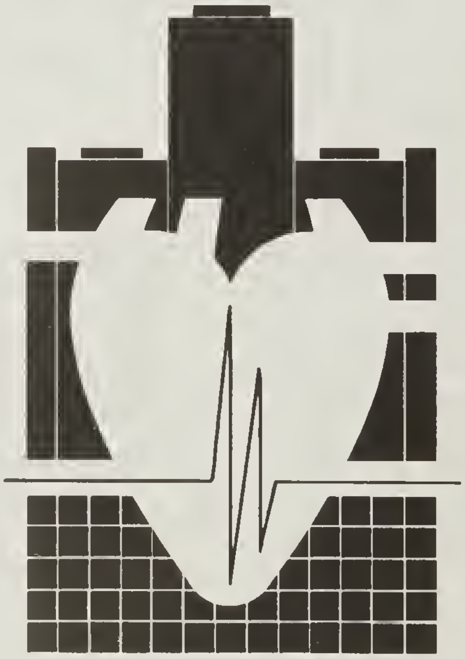
A final lesson, a bit more controversial, might be whether Michigan physicians facing cases similar to Culham's should or should not seek a court order before proceeding. Judge Breck's order gave no specific guidance on this.

My own view, as a physician with an ethics specialization, would be to discourage such action, in the face of virtually unanimous judicial support around the country for the good-faith actions of physicians who remove life support at patients' or family's request. I concur with the 1983 President's Commission report that the courts should be reserved for cases that cannot be resolved by discussions among physician, patient, family, and hospital staff.

Attorney McCleary expressed a different point of view and offered his advice (with which Judge Breck concurred) that physicians ought to seek a court order. He noted that in all such cases, physicians have won in the end; but they might have been subjected to great inconvenience and expense along the way. Until a higher Michigan court sets a firm precedent, physicians might find it advisable to seek judicial immunity, especially in cases where at least one relative disagrees.

Conclusion

Three days after the court ruling, Doctor Glassberg carried out Mr. Culham's wishes in his daughter's apartment, and Mr. Culham died peacefully one hour and 20 minutes later. It was reported that one of Mr. Culham's last communications was to express gratitude to the judge for the favorable ruling. ☐



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MDPH recommendations for physician office laboratories

By James T. Sgouris, DO, PhD

The last decade has seen an increase in the number of facilities as well as the number of tests being done in physician office laboratories. The sophistication of office testing varies from the simple dipstick to a full complement of procedures, including those that used to be too expensive and complex.

Several factors have contributed to making physician office testing more attractive. These include: (1) development of highly-sensitive and specific-reagent systems and their packaging into simple kits; (2) the development of user-friendly instrumentation; (3) convenience; and (4) changing concepts of health care.

Along with this tremendous expansion of physician-office testing has come deep concerns about the quality of such testing. The physician has the responsibilities for the accuracy of the results, but without personnel with adequate technical training, he or she can be lulled into a false sense of security by the apparent ease of operating the testing apparatus. These concerns have resulted in a call to monitor and even license these facilities. Many states have already done so.

In Michigan we license only physician office laboratories that are operated by six or more physicians. The remaining physician office laboratories, which constitute the majority, are not monitored or licensed by the State.

With the objective of improving the standardizing operations of these laboratories, we make the following recommendations.

(1) **Laboratory Manual.** Each physician office laboratory must have a laboratory manual covering all procedures done by that laboratory and reviewed yearly and signed by the responsible physician.

> **"The physician has the responsibilities for the accuracy of the results, but without personnel with adequate technical training, he or she can be lulled into a false sense of security by the apparent ease of operating the testing apparatus."**

(2) **Personnel Qualifications**

- Manufacturers are responsible for providing, with their testing systems, commentary pursuant to those educational and skill levels required for operators.
- Physicians must conform to recommendations by manufacturers pursuant to qualification number 1.
- Laboratory personnel must have a high school education (or equivalent) plus necessary training and education commensurate with the difficulty of test systems offered (covers both prepackaged, manufacturer-based systems and other methods (e.g., cell counting, WBC differentiation, urinalysis microexamination, microbiology).
- Education and skill levels pursuant to qualification number 3 would be attested to by the physician.

(3) **The physician's office laboratory should utilize equipment (or kits)** from manufacturers who would promptly train the staff in their use and establish satisfactory quality control procedures for each parameter.

(4) **All equipment** (refrigerators, water baths, centrifuge, etc.) **must be monitored** at appropriate intervals to assure proper operation. A record of this monitoring must be kept. Manufacturers of this equipment should provide information concerning recommended maintenance intervals to ensure proper operation.

(5) **We recommend an adequate quality control program** for each test procedure and documentation of quality assurance. A quality control sample should be run in conjunction with the patient's sample at a minimum of one per day when the laboratory is in operation. Quality control samplings need be run only for those tests which are performed in a given day.

Continued on page 138

Doctor Sgouris is Special Projects Administrator, Laboratory and Epidemiological Services, MDPH.

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LABORATORIES/Continued

(6) The laboratory should enroll in a proficiency testing program from a State-approved program (CAP1, AAB2, ASIM3). The proficiency tests conducted should encompass all areas of tests offered by the laboratory. A copy of the results of each survey should be sent by the CAP, AAB or ASIM directly to Laboratory Improvement Division of the Michigan Department of Public Health for review.

(7) Clinicians should avail themselves of expertise in their communities (hospital and independent laboratories) when they reach the limits of their knowledge and competency.

Further information can be obtained from the Michigan Department of Public Health by calling (517) 335-8153. Physicians may also contact the following organizations for information:

The College of American Pathologists (CAP)
740 North Skokie Boulevard
Skokie, IL 60077
Telephone (312) 966-5700

The American Association of Bioanalysts (AAB)
205 West Levee Street
Brownsville, TX 78520
Telephone 1-800-243-5315

American Society for Interna Medicine Medical Laborator Evaluation (ASIM/MLE)
1101 Vermont Avenue, NW,
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AIDS update

The MSMS AIDS Speaker's Bureau recom- nends the following articles for those interested n a comprehensive and timely review of HIV in- ection and other issues surrounding AIDS. Re- rints of the articles may be obtained by contac- ing Rose Heald at MSMS.

Bayer, R. et. al., **HIV antibody screening: An thical framework for evaluating proposed pro- rams**; JAMA 1986; 256; 1768-74.

Meyer, K.B. et. al., **Screening for HIV: Can ve afford the false positive rate**; NEJM 1987; 317: 38-41.

Cleary, P.D. et. al., **Compulsory premarital creening for HIV: Technical and public health onsiderations**; JAMA 1987; 258: 1757-62.

Zuger, A. et. al., **Physicians, AIDS and occupa- ional risk: Historic traditions and ethical obliga- ions**; JAMA 1987; 258: 1924-8.

Gostin, L. et. al., **The limits of compulsion in ontrolling AIDS**; Hastings Center Reports 1986; 6 (6) (suppl) **AIDS: Public Health and Civil iberty.**

Friedland, Gerald H., Klein, Robert S., **Trans- nission of HIV**; NEJM 1987; 317: 1125-35.

Mobilizing Against AIDS: The Unfinished Story f a Virus, Institute of Medicine, National Acad- my of Sciences, Harvard University Press, Cam- ridge, Mass. 1986.

Surgeon General's Report on: Acquired Im- nune Deficiency Syndrome, US Department of Iealth and Human Services, available from the Iichigan Department of Public Health.

The AIDS Speaker's Bureau also recommends he following pamphlets and publications for those nterested in obtaining an overview of AIDS issues. The AIDS Speaker's Bureau has in stock a limited upply of each pamphlet publication. For bulk rders, see addresses listed below.

AIDS: 100 Common Questions and Answers, pecial Office on AIDS Prevention, Center for Iealth Promotion, Michigan Department of Pub- ic Health, P.O. Box 30035, Lansing, Michigan 8909, January 1987.

Continued on next page

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CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest Hyperkalemia may complicate any of the following conditions. Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g . spironolactone, triamterene)

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g . spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet These micro-crystalloids are formulated to provide a controlled release of potassium chloride The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g , incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity K-DUR should be given to a pregnant woman only if clearly needed

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE).** There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS);** other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose

Skin rash has been reported rarely

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3 Correction of acidosis, if present, with intravenous sodium bicarbonate
4 Use of exchange resins, hemodialysis, or peritoneal dialysis

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

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AIDS UPDATE/Continued

AIDS Update, Michigan State Medical Society, AIDS Education Project, P.O. Box 950, East Lansing, Michigan 48826-0950, October 1987.

What You Should Know About AIDS, Facts about the disease; How to protect yourself and your family; What to tell others. (US Public Health Service, Centers for Disease Control); Michigan Department of Public Health, Special Office on AIDS Prevention, P.O. Box 30035, Lansing, Michigan 48909, 1987.

AIDS and Everyone, Michigan Department of Public Health, Special Office on AIDS Prevention, P.O. Box 30035, Lansing, Michigan 48909, 1987.

Health Update: AIDS in the Workplace, Michigan Department of Public Health, Special Office on AIDS Prevention, P.O. Box 30035, Lansing, Michigan 48909, October 1987.

Meeting set

The AIDS Speaker's Bureau also recommends **AIDS: A Call to Knowledge and Understanding,** a day long educational meeting slated for April 29 at the Ramada Hotel in Southfield, Michigan. The keynote address will be given by Evelyn Fisher, MD, Infectious Diseases Division, Henry Ford Hospital. The meeting, a continuing education conference, is cosponsored by the American Academy of Medical Administrators Research and Education Foundation Inc., and St. John Hospital, Detroit. For more information, contact Rose Heald at MSMS. ☐

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School workplace wellness: movin forward with physician support

By Richard Murdock

Consider the following as a potential for our state: school-based employees leading healthy lifestyles; and schools fostering "healthy" climates for the growth of comprehensive school health education programs for students. Is this possible in our health care cost-containment environment? The answer is a resounding yes and physician support and leadership has contributed in several notable ways.

This potential is becoming a reality due to the Island Conference for School Workplace Wellness, now entering its third year of operation. This conference was initiated and planned in the fall of 1985 with the first session held in June of 1986. Nearly 300 participants attended that first Island Conference representing 44 Michigan school districts.

The second Island Conference, held in June of 1987, drew over 500 participants representing 62 Michigan school districts. Planning is now underway for the third annual Island Conference for 1988.

More than a conference

The Island Conference is rapidly developing a reputation as an experience that must be shared with colleagues, family, and friends. Indeed the purpose of the conference is exactly that: to acquaint participants with the personal experiences and potential that a healthy lifestyle can bring to their lives, and to provide the methods needed to incorporate such experiences into a program.

With invitations extended only to superintendents of school districts (for them to send a team to represent their district) and no other promotional activity undertaken, it is apparent that the sponsors are serving a need since waiting lists were established last year because of limitations on available space.

The conference location, Mackinac Island, offers a site away from the many interruptions of everyday life, suitable for learning many of the skills, knowledge and attitudes necessary for changing lifestyles.

A week-long schedule of workshops, keynote speakers, opportunities for fitness and stress relaxation, and informal sharing activities combined with a "team" obligation to develop their local action plans for planning, initiating, or expanding a district workplace wellness program, has proven to be a successful formula.

Physician involvement

The Michigan State Medical Society is one of 18 sponsors of the Island Conference and was one of the earliest supporters. This involvement established credibility behind the Island Conference and aided in recruiting other organizations. Moreover, in each of the first two years of the conference, individual physician have provided workshops fo conference participants.

Last year as an example, Doctor Joan Stryker provided tw sessions on "Preventing Osteoporosis: The Silent Epidemic" Doctors Marguerite and Marsha Shearer provided workshops o "Sexual Health"; and Docto Richard Tooker provided a workshop on "What you need to know about AIDS." Additionally, in special mid-winter worksho held in Lansing last January Doctor Joseph Arends provide the keynote address.

It is expected that these session and others involving physician will be planned for future conferences and related workshop More importantly, as local schoo districts begin to establish an operate their local wellness programs for employees, they will b looking for assistance and involvement of local physicians.

Future conferences

The dynamics of the healt care system have resulted in several notable transformations. Th first is that individuals are becoming more aware of their personal health needs and what the can do for themselves in addressing those needs. Often this cal for changes.

The second and equally important, is our ability to link lifestyl or health risk factors, and consequences in terms of both morta ity/morbidity and health ca

The author is a health consultant with the Office of Health & Medical Affairs and acted as Island Conference coordinator.

osts. Employers, especially those vho are self-insured, are reviewing program options that can afect these relationships and develping appropriate policies and rograms.

The Island Conference is esablished to help school districts lan, operate and evaluate their mployee wellness programs. In ts short history, the Island Conerence has evolved to meet the hanging environment. The ponsors have recently changed ts operation from that of operatng under an "ad hoc" structure to recommending that conference operations be housed under the Michigan Health Council with the maintained involvement of the current sponsors.

Finally, Michigan is one of 26 states that holds a statewide conference for school workplace wellness. In an attempt to establish coordination with these conferences, the Island Conference supporters are seeking the establishment of a national network and have received encouragement from other states and national organizations. This activity should lead to the identification and sharing of national resources for school districts as wellness programs continue their growth.

In summary, wellness has grown beyond its conceptual stage. With the assistance of physicians, the growth of wellness programming will remain based upon sound principles. Information and school workplace wellness will continue as a setting for leadership in this field because of the Island Conference and its supporters. ☐

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Handling insurance company requests for patient information

Editor's note: Physicians must know their legal rights, obligations and responsibilities to their patients to avoid unnecessary lawsuits. However, keeping up-to-date on all the latest legal "dos and don'ts" isn't an easy task. To help MSMS members keep abreast of their rights, *Michigan Medicine* will occasionally feature a legal "question and answer" column. MSMS members are invited to submit questions to *Michigan Medicine*, and, with the help of MSMS legal counsel, Richard D. Weber, of Kerr, Russell and Weber, Detroit, *Michigan Medicine* will do its best to provide some answers. This month's debut column addresses three questions concerning the legal obligation of physicians to honor insurance company requests for patient information.

Question: When someone who says they are with an insurance company contacts a physician by phone asking for confidential information about a patient, what rights and responsibilities does the physician have to verify the validity of the caller's request? What kind of documentation of the caller's request should the physician have?

Answer: In order to disclose confidential patient information to a third party, a physician should receive a written waiver and consent signed by the patient authorizing the dissemination of the information. Health insurance contracts often include such waivers. In addition, the physician should receive satisfactory identification that the person requesting the information is within the authority granted by the patient. In the instance of an insurance carrier, this means that the insurance company should be identified in the waiver and consent signed by the patient, and a representative should submit satisfactory proof that he/she is a representative of that insurance company. The physician has the legal responsibility to comply with these requirements. Otherwise, the physician will be deemed to have violated the physician-patient privileges.

Question: In the above-described situation, the caller was from an obscure, out-of-state insurance company. Can the physician refuse to provide such information over the phone? How can the physician be certain that the request is legitimate? What responsibility does the physician have to his patient to verify that the person on the other end of the phone is who he says he is? It is reasonable for the physician to require that such a request be in writing?

Answer: The physician most certainly can and probably should refuse to provide such information over the phone, unless specifically authorized by the patient. The physician should verify that the request is legitimate by insisting upon appropriate identification. This verification is the responsibility of the physician in order to assure compliance with the physician-patient privilege o confidentiality. Remember, th privilege belongs to the patient not the physician. Only the patient may waive the privilege Therefore, the two-pronged tes set forth in the answer to the firs question is essential. It is mos reasonable for the physician t require that any such request b in writing.

Question: Does the physician have the right to bill (and collect the insurance company for spending his time (e.g. 15 minutes) t provide the background information on the patient?

Answer: The insurance company will only be obligated t pay the physician for his time i there is an expressed or implied agreement. This is probably impractical except in extenuated cases. Absent an agreement however, the physician would have no legal recourse. On th one hand, there is no law that requires that the physician cooperate and provide such information. On the other hand, such refusal may be impractical fo the reason that the insuranc company may not pay the physician or the patient. ☐

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Contraindications: There are no known contraindications to the use of 'Tagamet'.

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In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

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Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

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'Tagamet' HCl (brand of cimetidine hydrochloride) Injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

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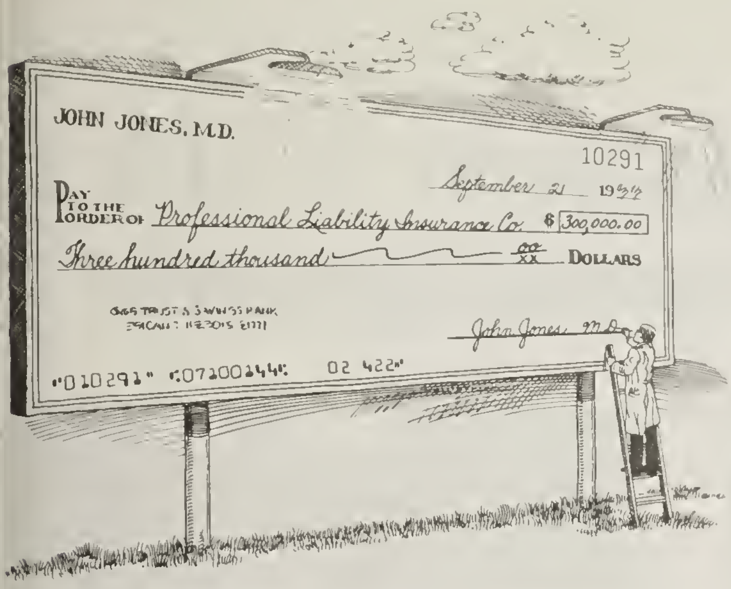
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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter. 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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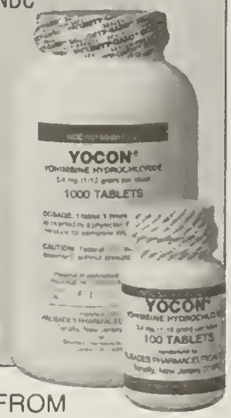

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Three students from Wayne State University were among the winners of the AMA "Member Get A Member" contest. Winners Bradley Miller (left) and Christopher Bajzu are shown above. Fellow WSU student Keith Papendick was not able to attend the photo session. Two University of Michigan students were also among the winners. Juan Vasquez and Jim Ilko could not be present for the photo session.

Also a winner of the AMA member recruitment contest Melinda Donovan, a medical student from Michigan Stat University.

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U-M receives grant to study diabetes

The University of Michigan Medical Center has received a federal grant of approximately $11.2 million that will greatly expand the study of problems related to diabetes.

The grant from the National Institutes of Health (NIH) to the Michigan Diabetes Research and Training Center was announced recently by Rep. Carl Pursell, R-Plymouth. Rep. Pursell is a member of the House, Labor, Health and Human Service Subcommittee in the House of Representatives that allocates funds for NIH programs.

Center Director Douglas M. Greene, MD, said the grant will support research of better treatment and possible cures of diabetes.

"The purpose of the grant is to support a multi-disciplinary, interdepartmental center to study problems related to diabetes," said Greene, a professor of internal medicine at the U-M Medical School.

Neurosurgical Institute established

Doctors at Henry Ford Hospital have created a Neurosurgical Institute, a network of neurosurgeons making quality neurosurgical care easily accessible to more patients. Henry Ford Hospital in Detroit is the home base. The Institute has affiliates in Cottage Hospital in Grosse Pointe Farms, Alachua General Hospital in Gainesville, Florida, and La Mutua de Accidents de Zaragoza in Spain.

James I. Ausman, MD, Henry Ford Hospital Neurosurgery chairman, initiated and heads the Institute.

Cocaine use among teens declining, study shows

The first substantial decline in cocaine use among American high school seniors, college students and young adults was detected in a 1987 drug survey conducted by researchers at the University of Michigan's Institute for Social Research (ISR).

Social psychologists Lloyd D. Johnston, Jerald G. Bachman and Patrick M. O'Malley cautioned that although overall drug usage among young people continued a trend of gradual decline last year, the United States still has the highest rate among the world's industrialized nations.

Even with the modest improvement in the cocaine situation and other cooling of what they call "the unhealthy romance between many of America's young people and illicit drugs," the U-M researchers insist that "we have come only part way down from a very high mountain, and to a considerable degree that is true of the drug problem in general."

Over half (57 percent) of last year's high school seniors still had tried an illicit drug, and over a third had tried an illicit drug other than marijuana.

The survey found little change in the use of LSD, heroin or other opiates, and there was some evidence of a continuing gradual increase in the use of inhalants.

The use of alcohol was little changed, and cigarette smoking —which the researchers say will take the lives of more young people than all other drugs combined —has not dropped among high school seniors since 1984.

The Hudson-Webber Foundation has awarded Harper Hospital, a member of The Detroit Medical Center, a grant of $1 million for capital enhancements to its cardiology program.

The grant will be used to further develop such facilities as the hospital's laser laboratory, where research is being done into the use of lasers to open up blocked or narrowed arteries. It also will support work in balloon angioplasty and valvuloplasty (the use of balloons to repair the damage in the heart and arteries).

Medicaid reimburses aspirin for arthritis

Through cooperative efforts of the Arthritis Foundation, Michigan Pharmacists Association, the Michigan Department of Social

Continued on page 155

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Before prescribing, please consult Brief Prescribing Information on next page.

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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company **2.** Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al Liquid and solid potassium chloride: Bioavailability and safety *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21 436-440.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function, potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e g , spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g , spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic *acidosis* should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per* se can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per* se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium

Information for Patients

Physicians should consider reminding the patient of the following

To take each dose without crushing, chewing, or sucking the tablets

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed

Laboratory Tests

Regular serum potassium determinations are recommended In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis

Drug Interactions

Potassium-sparing diuretics: see WARNINGS

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L It is not known if Slow-K has an effect on this content Caution should be exercised when Slow-K is administered to a nursing woman

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8 0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion Large numbers of tablets should be given in divided doses

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked

HOW SUPPLIED

Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

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Accu-Pak® Unit Dose (Blister pack)	
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NEWSFRONTS/Continued

Services and other study groups, Medicaid began reimbursing for aspirin on July 1, 1985. The aspirin inclusion may actually result in a savings for the Department, given the cost of other less safe nonsteroidal anti-inflammatories.

A prescription is required for aspirin reimbursement and there will be no recipient copayment. Due to the wide price variance between many types of aspirin products, therapeutic drug price limitations for general types of products were set. Listed below are the aspirin types which reflect the varying strengths covered for each product type within the therapeutic drug price limit: Aspirin Tablet, 5 grain or 325 mg.; Aspirin Tablet, 10 grain, 500 mg. or 650 mg.; Aspirin Enteric Coated, Tablet, 5 grain or 325 mg.; Aspirin and Antacid Combinations, (Buffered) Tablets, 5 grain or 325 mg.

Products that were not economical were deleted. Pharmacies and drug wholesalers were then surveyed regarding the estimates of average costs to pharmacies for the remaining therapeutic types. The therapeutic price limit was then set to offer a wide range of quality aspirin products.

Prescribers may choose to indicate the drug products generically as listed above. Pharmacy providers can assist prescribers in the choice of products available at the therapeutic drug price limits.

Any questions regarding the aspirin inclusion should be directed to Medicaid Information Division, Medical Services Administration, PO Box 30037, Lansing, MI 48909 or phone toll free 1-800-292-2550 (outside of Michigan call (517) 373-7605.) Please refer to Medical Assistance Program Bulletin 5385-85-04 with your inquiries.

Yeast infections studied

A number of studies involving women with yeast infections are being conducted by the Wayne State University/Hutzel Hospital Vaginitis Clinic located in the C.S. Mott Center for Human Growth and Development. If a woman is qualified, medicine and office visits will be provided free while she is on the study.

Participating women must not be pregnant, must have an actual infection and must not have been on any yeast medication for at least two weeks prior to her first visit. For further information or patient referrals, call (313) 745-0457.

New ways to detect viral infections

A new type of light-producing chemical compound will provide ultra-sensitive diagnostic methods for detecting viral infections such as hepatitis and AIDS and for evaluating genetic diseases, says a Wayne State University researcher. In agriculture, the new compound will help identify viruses in plants before the whole crop is infected.

Wayne State chemist Doctor A. Paul Schaap recently synthesized this new type of chemical compound that can be triggered with biological catalysts, called enzymes, to produce light at room temperature. He has used these chemiluminescent (chemical light) materials as detectors of enzymes, antigens and antibodies from body fluid. These provide for the early detection of viral infections and other diseases.

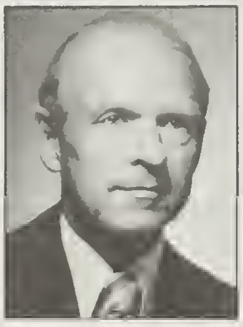
Photopheresis investigated

Doctors at Henry Ford Hospital are investigating photopheresis, a new form of therapy involving a drug in conjunction with ultraviolet (UV) light, to treat some patients suffering from cutaneous T-cell lymphoma, a potentially life-threatening malignancy that begins in the skin and causes an extremely itchy, uncomfortable skin eruption.

Photopheresis is unique because it is the first form of therapy where the interaction between the drug and UV light takes place outside the body, according to dermatologist Margaret Douglass, MD, who heads the photopheresis program at Henry Ford Hospital, one of only 12 centers in the US using the treatment.

PHYSICIANS IN THE NEWS

Silver


Murray

Enzer

Ausman

Sentkeresty

O'Brien

Inad Haddad, MD, Adrian, has been appointed chief of staff at Emma L. Bixby Hospital.... **Terry M. Silver, MD**, Ann Arbor, professor and associate chairman, Department of Radiology, University of Michigan, received special recognition during the recent annual meeting of the American College of Radiology. Doctor Silver was named as one of the 104 fellows by the college's Board of Chancellors.... **Clyde Spencer, MD**, Lansing, a Board-certified radiologist, has been elected chief of the medical staff at Sparrow Hospital.... **Thomas LeGalley, MD**, Marquette, has been named vice-president of the newly-formed Michigan Chapter of American College of Cardiologists.... Governor James J. Blanchard recently announced the appointment of **George Tsiatalas, MD**, Birmingham, a general surgeon, to the Mental Health Advisory Council.... **Sid Gilman, MD**, Ann Arbor, professor and chairman of the University of Michigan Medical School Department of Neurology, has been named president-elect of the American Neurological Association.... **Raymond Murray, MD**, East Lansing, chairperson of the Department of Medicine, is a member of the Agent Orange Commission, established by Governor James J. Blanchard to review the effects among Michigan Vietnam War veterans of the chemical defoliant.... **Norbert Enzer, MD**, East Lansing, Michigan State University professor of psychiatry, received the Honorary Distinguished Physician Award from the American College of Neuropsychiatrists at the group's annual meeting.... Michigan native **Paul Campana, MD**, is the subject of a feature story which ran recently in the Crystal Falls *Diamond Drill*. Doctor Campana, a Wayne State University School of Medicine graduate, has practiced medicine in many European and American locations as a substitute for colleagues who need time away from their practices. He is licensed to practice in every US state, but makes his home in Italy, where his wife, Ela and daughter, Carla, live.... **Glenn C. Davis, MD**, Troy, has been named chairman of psychiatry at Henry Ford Hospital.... **James I. Ausman, MD**, Bloomfield Hills, chairman of neurosurgery at Henry Ford Hospital, was appointed recently to the Board of Editors of Surgical Neurology, one of three neurosurgical journals in the United States.... **Howard J. Sawyer, MD**, Southfield, has joined Henry Ford Hospital as director of its new Occupational, Environmental and Preventive Medicine Division. ...**Joseph A. Sentkeresty, MD**, Grand Rapids, was installed as president of the 800 member Kent County Medical Society at its annual meeting January 12. **Paul O. Farr, MD**, Grand Rapids, was elected secretary-treasurer, and **Jack L. Romence, MD**, Grand Rapids, was elected director. ...**James G. O'Brien, MD**, East Lansing, professor and associate chairperson of Michigan State University's Department of Family Practice, College of Human Medicine, has been cited for his work with the state's older population by the Michigan Society for Gerontology. He was presented with the 12th annual V.K. Volk Award for health services at the organization's annual conference at MSU. □

IN MY OPINION/Continued

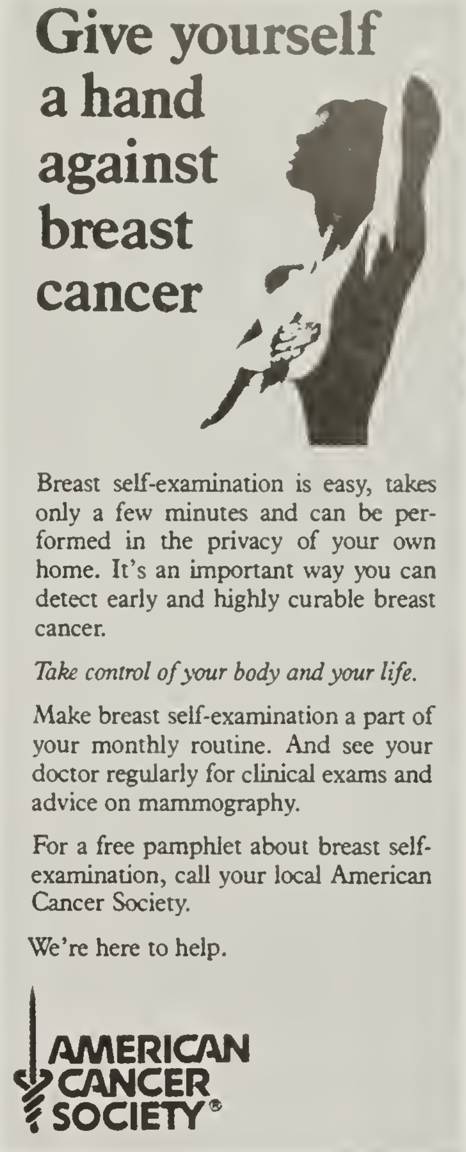
gan *Medicine* brings you up to date on some of the recent changes in Medicare physician reimbursement policies. This update is developed with AMA staff help.

Perhaps you have some suggestions on how the Federal Government could improve the system. Perhaps you have specific accounts of how the Medicare reimbursement system works in your practice.

As chairman of the MSMS Committee on Publications I invite you to share your opinions and suggestions with your colleagues in future issues of *Michigan Medicine*.

We will print the most thoughtful and constructive contributions. We will share all of them with our congressional representatives.

We would like to hear from you. Write Committee on Publications, MSMS, PO Box 950, East Lansing, 48826-0950. ☐



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All referrals receive a complete health history, an OB/GYN evaluation, a diabetes and a diet evaluation, counseling on diabetes and pregnancy, and treatment for any identified health problems.

We also help diabetic women prepare for changes in medication, diet, work and exercise during their pregnancy.

For further information, referral or consultation, please call Robert Hayashi, M.D. or William Herman, M.D. at 1-800-962-3555 and learn more about how this new Service is helping diabetic women experience healthier pregnancies.

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DEATHS

Jean Fairchild, MD
Spring Lake

Doctor Fairchild died December 20 at the age of 61. Doctor Fairchild was a consulting psychiatrist for Ottawa County Community Mental Health, specializing in care of the chronic mentally ill, working in Grand Haven and Holland. She obtained her medical degree at the University of Louisville in 1956 and did her psychiatric residency at Louisville General Hospital. She was a member of the Michigan State Psychiatric Association, West Michigan Psychiatric Society and Ottawa County Medical Society.

W. Meridith Green, MD
Bloomfield Hills

Doctor Green died December 20 at the age of 84. Doctor Green was an obstetrician and delivered more than 20,000 babies in his 55 years of practice in Pontiac. He was a graduate of the University of Toronto Medical School and did his residency at Case Western Reserve in Cleveland. He was a member of the American Medical Association, Oakland County Medical Society, American College of Obstetricians and Gynecologists, American College of Surgeons, and the Michigan Society of Obstetricians and Gynecologists.

Harry Greenbaum, MD
Jackson

Doctor Greenbaum, a specialist in obstetrics and gynecology, died December 28 at the age of 80. He was past president of the Jackson County Medical Society and former chief of staff of both Foote and Mercy hospitals. In 1982 he received a resolution of tribute from Rep. Michael J. Griffin through the Michigan Legislature and a similar resolution from the city of Jackson in 1982. He was an Army veteran of World War II, where he served four years in the medical corps.

Robert H. Hamburg, MD
Birmingham

Doctor Hamburg died January 15 at the age of 66. He was former vice-chairman of the Blue Cross Blue Shield Board of Directors. Doctor Hamburg was a graduate of the Wayne State University School of Medicine and was former chief of internal medicine and a member of the medical executive committee at Harper Hospital. Doctor Hamburg was a long-time member of the MSMS House of Delegates, member of the Advisory Committee to the MSMS Section on Medical Economics, and a director of the Physicians Review Organization of Michigan.

Eugene Nakfoor, MD
Lansing

Doctor Nakfoor, former director of emergency medicine at St. Lawrence Hospital, died January 23. He graduated from Michigan State University were he received his bachelor's and master's degree. He received a doctor of medicine degree from the University of Michigan in 1964. Doctor Nakfoor served his internship at St. Lawrence and entered private family practice. He was a founder of the American College of Emergency Physicians, chief of staff at St. Lawrence and was past president of the Ingham County Medical Society.

Dennis Roman, MD
Roseville

Doctor Roman, a Detroit anatomic and clinical pathologist, died November 23 at the age of 37. He was a graduate of Wayne State University. A residency in pathology at St. John Hospital and worked there until he was granted a Mayo Clinic fellowship in pathology and microbiology.

Harry C. Saltzstein, MD
Livonia

Former chief surgeon at Sinai Hospital, Doctor Saltzstein died November 11 at the age of 97. Doctor Saltzstein was a 1910 graduate of Yale University and in 1914 received a medical degree from Johns Hopkins University School of Medicine. He earned the rank of captain in the Army Medical Corps in France in World War I. He was a fellow of the American College of Surgeons, a member of the American Board of Surgery, Wayne County

Continued on page 162

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through Katie Brewbaker
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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Roger B. Anderberg, MD — PD
2422 Packard
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H. Frank Andersen, MD — OBG
L-3223 Women's Hosp. Box 2064
Ann Arbor 48109

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Traverse City 49684

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200 S. Wenona
Bay City 48708

James D. Bash, DO — FP
Tolfree Hospital
West Branch 48661

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Holland 49423

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Haslett 48840

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Grosse Pte. Park 48230

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408 Jillboro Drive
Birmingham 48010

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Muskegon 49440

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Menominee 49858

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Greenville 48838

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Detroit 48201

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547 Maiden Lane
St. Joseph 49085

George Economopoulos,
MD — CD
4160 John R #829
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Continued on page 169

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FPR

Pain pathways page 63

Family Practice Recertification

JULY 1987 VOL 9 NO

CLINICAL ARTICLES

Endometrial Cancer: Causes and Patient Evaluation

Pain Management in Primary Care

Controlling Side Effects of Antipsychotic Drugs, Part 2: Extrapyramidal Symptoms

Osteoporosis, Part 2: Prevention and Treatment

KEEPING CURRENT

Assessing Impairment of Elderly Hospitalized Patients

Routine Radiological Testing for Respiratory Illness

Using Ultrasound to Detect Hip Abnormalities

Diagnosing Bone Infection Under Pressure Sores

Slowing Progression of Diabetic Nephropathy

Behavioral Disorders Among Children of Alcoholic Fathers

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DEATHS/Continued

Medical Society, Detroit Surgical Society, and American Association of Hospital Medical Education.

W. Kenneth Tregenza, MD
Bloomfield

Doctor Tregenza died December 7 at the age of 79. He was a former chief of staff at Crittenton Hospital in Rochester. Doctor Tregenza, an obstetrician and gynecologist, was a Navy doctor during World War II. He began his civilian career at Crittenton Hospital in Detroit in 1946. A graduate of Wayne State University Medical School, he was awarded a golden anniversary diploma in 1985.

John E. Webster, MD
Grosse Pte. Farms

Doctor Webster died January 1 at the age of 78. He had practiced at Grace and Detroit Receiving hospitals. After graduating from the University of Michigan in 1930 with a degree in pharmacy, Doctor Webster earned a bachelor's degree, then a doctorate in medicine at Wayne State University. He also earned a doctor of medical science degree from the University of Pennsylvania. During World War II, he served in the Army Medical Corps as a major with the 36th General Hospital in the European Theater. He received the Legion of Merit for distinguished service.

William J. Yetzer, MD
Dearborn

Doctor Yetzer, a Dearborn obstetrics and gynecology specialist, died December 1 at the age of 72. He graduated from the University of Michigan Medical School and later served on staff of Grace Hospital. He was the director of medical education program at Oakwood Hospital, a member of Wayne County Medical Society and the AMA.

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Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

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Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

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References:
1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 62-69, 1984.

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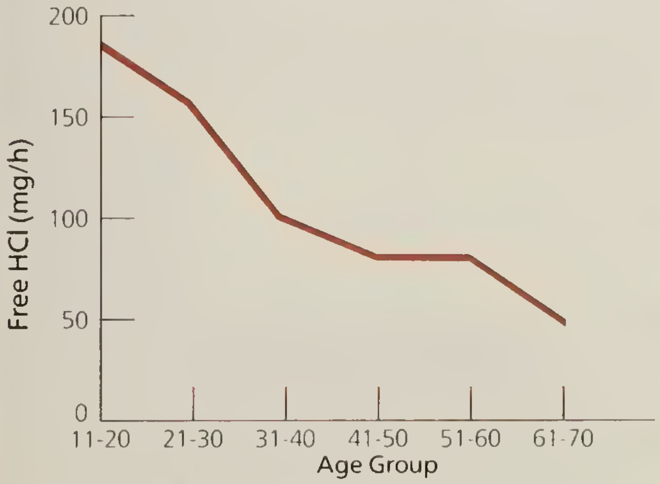

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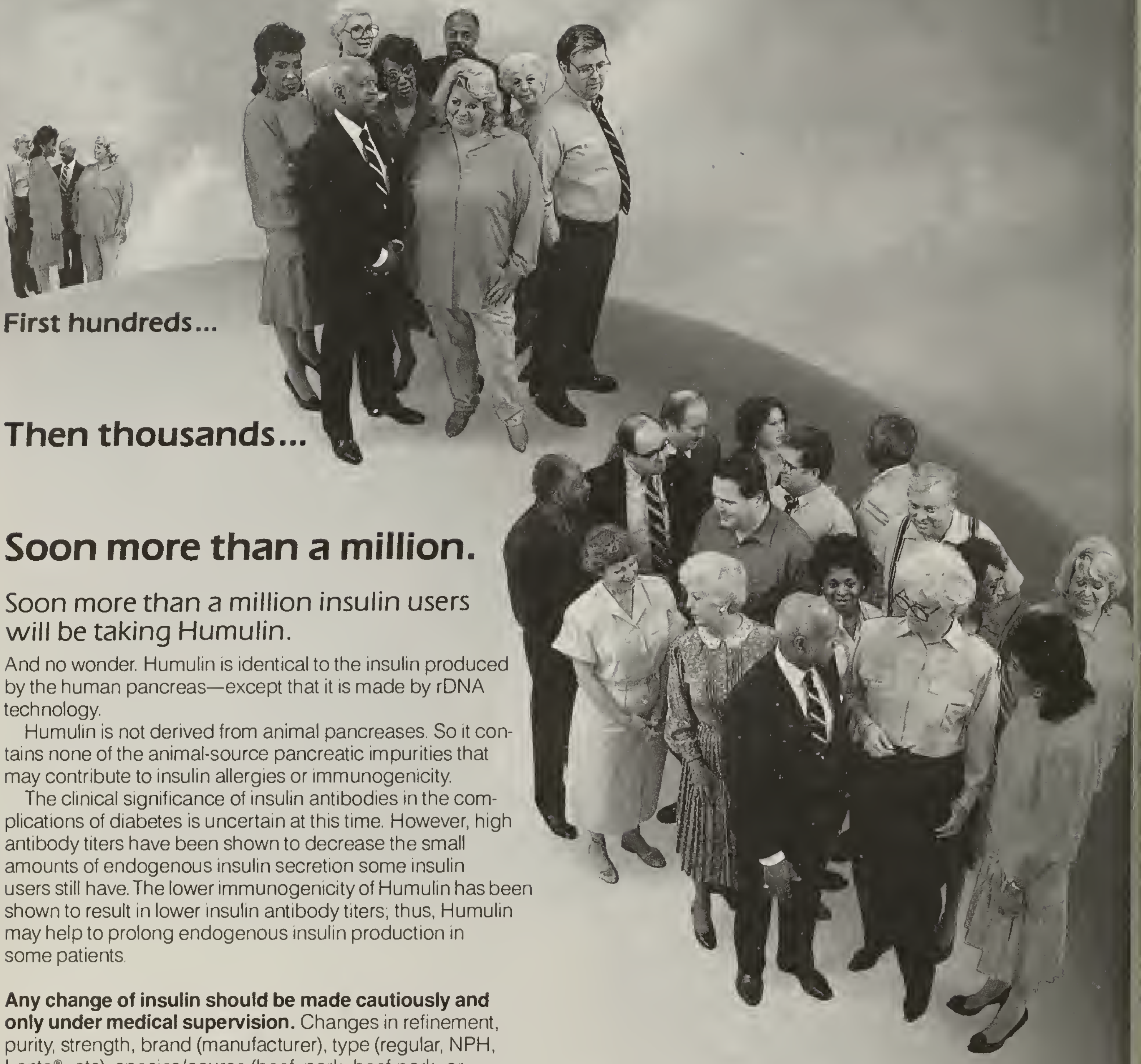

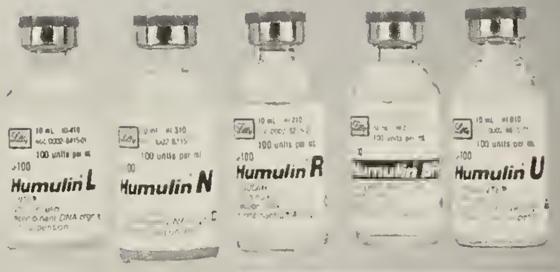

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The MSMS Physician Legislative Network is a program designed to give the physician a "hands on" look at the legislative process in Michigan.

Many MSMS members are acquainted with important legislators and government officials and are willing to employ these acquaintances to advance the legislative efforts of the medical profession.

The MSMS Department of Government Relations maintains a list of these members and calls upon them for assistance when the need arises.

If you are willing to participate in this program, either "back home" or in Lansing, MSMS invites you to fill in the Physician Legislative Network form and return it to Daniel Farhat at MSMS headquarters. This information will be held strictly confidential and used only by MSMS in its contacts with you.

______ I'm interested in working with the "MSMS Physician Legislative Network"
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MICHIGAN STATE
18
66
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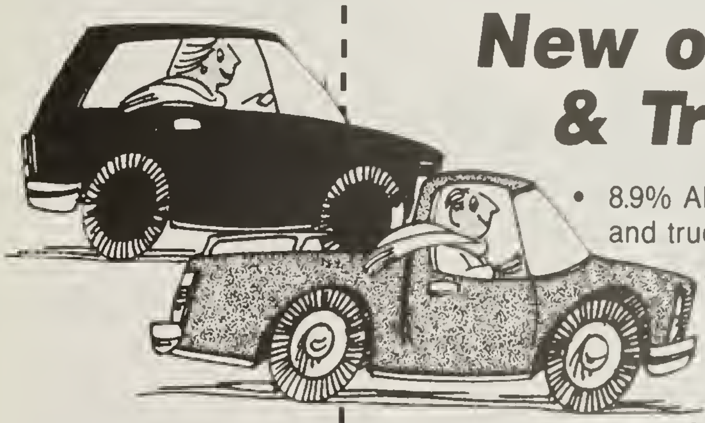

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Continued on page 176

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Ann Arbor 48104

James C. Segerson, MD — IM
1558 E. Michigan Ave.
Albion 49224

Sid M. Shah, MD — EM
2825 Staten Ave. #22
Lansing 48910

David L. Sharp, MD — FP
650 Three Mile Rd., NW
Grand Rapids 49504

Dennis N. Shelle, MD — IM/PD
402 E. Chicago Blvd.
Tecumseh 49286

Roger C. Sider, MD — P
300 68th St., SE
Grand Rapids 49508

Paul A. Sieving, MD — OPH
1000 Wall St.
Ann Arbor 48105

Hikmet H. Sipahi, MD — ON/IM
1700 Clinton St.
Muskegon 49442

Robert B. Sklar, MD — OBG
626 N. Crooks Road
Clawson 48017

Alvaro H. Skupin, MD — PUD
6767 W. Outer Drive
Detroit 48235

Gregory L. Skuta, MD — OPH
1000 Wall St.
Ann Arbor 48105

Delano R. Small, MD — IM/CD
22250 Providence Dr.
Southfield 48075

Patricia A. Smethurst, MD — PD
292 W. Chicago
Coldwater 49036

Thomas G. Smith, MD — FP
140 Paluster St.
Cadillac 49601

Continued on page 183

PSYCHIATRISTS
$61,679 - $95,421
(Depending on Training and Experience)

Positions are available throughout Michigan in an emergency program designed to provide comprehensive, coordinated and continuing care to mentally disordered prisoners within the Michigan Department of Corrections. Openings exist in a variety of settings, including acute inpatient units, long-term care units, transitional care units, and outpatient programs.

Excellent Civil Service fringe benefits, valued at about 47% of salary, include paid vacation, holidays, educational leave, sick leave, life and health insurance, retirement and deferred compensation.

Call or write:

S. Jenkins Phelps, M.D.
Assistant Director for Psychiatry
Bureau of Health Care Services
DEPARTMENT OF CORRECTIONS
Logan Square - 3222 S. Logan
Lansing, MI 48913
517/887-7900

An Equal Opportunity/Affirmative Action Employer

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

March

10-15, Ophthalmology: Basic and Clinical Review Course. Location: Hotel Pontchartrain, 2 Washington Boulevard, Detroit. Sponsor: Kresge Eye Institute of Wayne State Univesity School of Medicine. Contact: Division of Continuing Medical Education, Wayne State University School of Medicine, 4H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180. Approved for: 42 hours Category I Credit.

13-18, Emergencies in Medicine. Location: The Yarrow, A Dunfey Resort and Conference Center, Park City, Utah. Sponsor: Michigan Committee on Trauma, American College of Surgeons. Contact: Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit 48201 (313)745-3484. Approved for: 25 hours Category I Credit.

15, Patient Care for Practicing Physicians. Location: Clarion Conference Center, 6810 S. Cedar Street, Lansing. Sponsor: Ingham County Medical Society and MSMS Committee for Continuing Medical Education. Contact: Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)334-2320. Approved for: 6 hours Category I Credit.

16-18, A Symposium and Preceptorship in Diabetes Care. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School. Contact: Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 19 hours Category I Credit.

20-25, Facial Cutaneous Surgery: Mohs, Reconstructive, and Cosmetic. Location: Copper Mountain Resort, Copper Mountain, Colorado. Sponsor: The University of Michigan Medical School. Contact: Karen Brown, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 19 hours Category I Credit.

22-26, Family Practice—1988 Twelfth Annual Spring Refresher and Board Examination Review. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Family Practice and The Michigan Academy of Family Physicians. Contact: Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 33.75 hours Category I Credit.

23-24, 27th Annual Conference on Maternal and Perinatal Health: Issues in Primary Perinatal Practice. Location: Amway Grand Plaza, Grand Rapids. Sponsor: Michigan State Medical Society. Contact: Sherry L. Fent, Chief, Physician Education, Michigan State Medical Society, P.O.Box 950, East Lansing 48826-0950 (517)337-1351. Approved for: 13 hours Category I Credit.

April

7-9, 17th Annual Critical Care Symposium. Location: Kresge Auditorium, Harper Hospital, 3990 John R, Detroit. Sponsor: Wayne State University School of Medicine, Medical Education Seminars, Inc. Contact: Robert F. Wilson, MD, FACS, Department of Surgery, Detroit Receiving Hospital, 4201 St. Antoine, Detroit 48201 (313)745-3484. Approved for: 17 hours Category I Credit.

8-9, Advanced Trauma Life Support Instructor Course. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School. Contact: Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 18 hours Category I Credit.

9, Diabetes Mellitus: Achieving Control in Your Office Practice. Location: Amway Grand Plaza, Grand Rapids. Sponsor: Michigan Academy of Family Physicians and Eli Lilly & Company. Contact: Julie Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151. Approved for: 7.25 hours Category I Credit.

10-13, Extracorporeal Membrane Oxygenation for Neonatal Respiratory Failure (ECMO) Basic and Advanced Courses. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Departments of Surgery, Pediatrics and Communicable Diseases. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 15 hours Category I Credit for the basic course and 7 hours Category I Credit for the advanced course.

13, Educational and Health Perspectives of Dyslexia. Location: Western Michigan University, Kalamazoo. Sponsor: Michigan Dyslexia Institute, Michigan Department of Public Health, Michigan Branch of the Orton Dyslexia Society, SLD Center of Kalamazoo. Contact: Alice Hamachek, Michigan Dyslexia Institute, P.O.Box 23025, Lansing 48901 (517) 349-6522. Approved for: 5 hours Category I Credit.

14-15, Annual Postgraduate Course in Obstetrics and Gynecology: Challenges and Changes of the 1980s. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Obstetrics and Gynecology. Contact: Betty Phillips, Office of Continuing Medical Education, The Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 15 hours Category I Credit.

14-15, Pediatric and Adolescent Medicine for Primary Care Physicians. Location: Henry Ford Hospital, Room 2055, Education and Research Center, Detroit. Sponsor: Henry Ford Hospital, Department of Pediatrics, Detroit. Contact: Kathy Meyers, Henry Ford

Continued on next page

CATEGORY I COURSES/Continued

Hospital, Continuing Medical Education Office, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 15 hours Category 1 Credit.

15, **Michigan Allergy Society Spring Scientific Meeting: Immunologic Lung Disease. Location:** Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** Michigan Allergy Society and Michigan State Medical Society. **Contact:** Viola M. Heins, Michigan Allergy Society, P.O. Box 950, East Lansing, MI 48826-0950 (517)337-1351. **Approved for:** 3 hours Category 1 Credit.

16, **Emergency Medicine Oral Boards Preparation Course. Location:** St. Mary's Hospital, Saginaw. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians. **Contact:** Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. **Approved for:** 5 hours Category 1 Credit.

18-20, **Ultrasound in Obstetrics and Gynecology. Location:** The Towsley Center for Continuing Medical Education, The University of Michigan Medical School. **Sponsor:** The University of Michigan Medical School, Department of Radiology. **Contact:** Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 22 hours Category 1 Credit.

19, **Is There a Difference Between the Practice of Medicine and the Practice of Osteopathy? Location:** Clarion Conference Center, 6810 S. Cedar Street, Lansing. **Sponsor:** Ingham County Medical Society and MSMS Committee for Continuing Medical Education. **Contact:** Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)334-2320. **Approved for:** 6 hours Category 1 Credit.

20, **Sleep Throughout the Life Cycle. Location:** Fetzer Center at Western Michigan University, Kalamazoo. **Sponsor:** Borgess Pulmonary Services. **Contact:** Judy Smith, Pulmonary Services, Borgess Medical Center, Kalamazoo (616)383-4875. **Approved for:** 6 hours Category 1 Credit.

20, Stress in the Heart Brain Connection. Location: Amway Grand Plaza Hotel, Grand Rapids. Sponsor: Blodgett Medical Center with Grand Valley Internal Specialists, P.C. Contact: Raquelle Taylor, Blodgett Medical Center, 1840 Wealthy, S.E., Grand Rapids 49506 (616)774-7436. **Approved for:** 4 hours Category 1 Credit.

21-23, **Michigan Association of Osteopathic Physicians and Surgeons, Inc. 89th Annual Post-Graduate Conference and Scientific Seminar. Location:** Hyatt Regency Dearborn at Fairlane Town Center. **Sponsor:** Michigan Association of Osteopathic Physicians and Surgeons, Inc. **Contact:** Cathi A. Liebziet, Michigan Osteopathic Journal, 33100 Freedom Road, Farmington 48024 (313)476-2800. **Approved for:** 29 hours Category 1-A Credit.

28-29, **The Phlebotomy Team: Technical and Management Perspectives. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Pathology. **Contact:** Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 11 hours Category 1 Credit.

May

2-3, **Interventional Cardiology Symposium for Nurses. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 12 hours Category 1 Credit.

4, **Geriatrics—1988. Location:**Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center, 4th Floor Stryker, 1521 Gull Road, Kalamazoo. **Contact:** Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 4th Floor Stryker Center, 1521 Gull Road, Kalamazoo 49001 (616)341-6360. **Approved for:** 6 hours Category 1 Credit.

4-6, **Computed Tomography and Magnetic Resonance Imaging and Radiologic Technologist Program. Location:** The Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Radiology. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 22.5 hours Category I Credit.

5-6, **Annual Resident Surgeons Day and Michigan Chapter American College of Surgeons Program. Location:** Novi Hilton, Novi. **Sponsor:** Michigan Chapter, American College of Surgeons. **Contact:** Viola M. Heins, Michigan Chapter, American College of Surgeons, P.O. Box 950, East Lansing 48826-0950 (517)337-1351.

5-7, **National Conference on Health Care Leadership and Management. Location:** Sheraton Harbor Island, San Diego, CA. **Sponsor:** The American Academy of Medical Directors. **Contact:** Sherry Mason, AAMD, 4830 W. Kennedy Blvd, Suite 648, Tampa, FL 33609-2517 (813)287-2000. **Approved for:** 16 hours Category 1 Credit.

6, **Seminar in Computed Tomography and Magnetic Resonance Imaging. Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Radiology. **Contact:** Betty Phillips, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 22 hours Category 1 Credit.

9-13, **16th Annual Spring Update: Advances in Internal Medicine. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 34 hours Category 1 Credit.

16-17, **Recent Trends in the Electrophysiologic Assessment of Auditory Function: Neuro-Otologic and Intraoperative Applications; Pediatric and Neonatal Applications. Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School. **Sponsor:** University of Michigan Medical School, Department of Otolaryngology. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 14 hours Category I Credit.

MEETINGS

MICHIGAN STATE MEDICAL SOCIETY
1866

MSMS MEETINGS

March

23-24, 27th Annual Conference on Maternal and Perinatal Health: Issues in Primary Perinatal Practice, Amway Grand Hotel, Grand Rapids, contact: Sherry L. Fent, (517)337-1351.

April

29-5/1, MSMS Board of Directors and House of Delegates, Hyatt Regency, Dearborn, contact: William Madigan (517)337-1351.

May

19, MSMS Sports Medicine Conference, Hilton Inn, Lansing, contact: Sherry L. Fent (517)337-1351.

September

14, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

October

19, 1988 Public Affairs Leadership Conference, Hilton Inn, Lansing, contact: Mary Anne Ford (517)337-1351.

November

8-10, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent (517)337-1351.

16, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETINGS

April

7-9, Physician Competence: Whose Responsibility?, National meeting co-sponsored by American Medical Association, American Hospital Association and the Association of American Medical Colleges, Warwick Hotel, Houston, TX, contact: Ira Singer, AMA, Department of Public Information, 535 North Dearborn St., Chicago, IL 60610 (312)645-4655.

June

26-30, AMA Annual Meeting, Chicago Hilton and Towers, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4392 (312) 645-4344.

December

6-9, AMA Interim Meeting, Atlanta, GA contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4344.

MICHIGAN SPECIALTY SOCIETY MEETINGS

April

9, Diabetes Mellitus: Achieving Control in Your Office Practice, Michigan Academy of Family Physicians and Eli Lilly & Company, Amway Grand Plaza, Grand Rapids, contact: Julie Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151.

15, Michigan Allergy Society Spring Scientific Meeting: Immunologic Lung Disease, Amway Grand Plaza Hotel, Grand Rapids, contact: Michigan Allergy Society, Viola M. Heins, P.O. Box 950, East Lansing 48826-0950 (517)337-1351.

16, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500.

May

5-6, Annual Resident Surgeons Day and Michigan Chapter, American College of Surgeons Program, Novi Hilton, Novi, contact: Michigan Chapter, American College of Surgeons, Viola M. Heins, P.O. Box 950, East Lansing 48826-0950 (517) 337-1351.

21, Michigan Society of Pathologists Spring Meeting, St. Clair Inn, St. Clair, contact: Michigan Society of Pathologists, Viola M.

Continued on next page

Heins, P.O. Box 950, East Lansing 48826-0950 (517)337-1351.

June

17-19, Annual Meeting—Michigan Association of Neurological Surgeons, Grand Traverse Resort, Traverse City, contact: William F. Chandler, MD, 1500 E. Medical Center Drive, Ann Arbor 48109 (313)936-5020.

July

21, Fifteenth Michigan Emergency Medicine Assembly—EMS Concepts 88 and Base Station Symposium, Michigan Chapter of the American College of Emergency Physicians, Hilton Shanty Creek, Bellaire, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500.

25, 42nd Annual Scientific Assembly, Michigan Academy of Family Physicians, Grand Traverse Resort, Acme, contact: Julie L. Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151.

October

2, Michigan Chapter, American Academy of Pediatrics Annual Scientific Meeting, Grand Traverse Resort and Conference Center, Traverse City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018 (313)553-3646.

9, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500.

NATIONAL SPECIALTY SOCIETIES

March

20-23, American Society of Abdominal Surgeons Annual Scientific Meeting, Williamsburg Hospitality House, Williamsburg, VA, contact: American Society of Abdominal Surgeons, 675 Main Street, Melrose, MA 02176 (617)665-6102.

27-30, American College of Emergency Physicians Annual Meeting, Hotel Del Coronado, Coronado, CA, contact: American College of Emergency Physicians, P.O. Box 611911, Dallas, TX 75261-9911 (214)550-0911.

27-31, American College of Cardiology Scientific Meeting, Atlanta, GA, contact: American College of Cardiology, 9111 Old Georgetown Road, Bethesda, MD 20814 (301) 897-5400.

April

14-17, American College of Preventive Medicine Annual Scientific Meeting, Westin Peachtree Plaza, Atlanta, GA, contact: American College of Preventive Medicine, 1015 15th Street, N.W., Suite 403, Washington, DC 20005 (202)789-0003.

17-23, American Academy of Neurology Annual Meeting, /Convention Center, Cincinnati, OH, contact: American Academy of Neurology, 2221 University Avenue, S.E., Suite 335, Minneapolis, MN 55414 (612)623-8115.

18-20, American Association for Thoracic Surgery Annual Scientific Meeting, Century Plaza, Los Angeles, CA, contact: American Association for Thoracic Surgery, 13 Elm Street, Manchester, MA 01944 (617)927-8330.

23-29, American Occupational Medical Association Annual Meeting, New Orleans Marriott, New Orleans, LA, contact: American Occupational Medical Association, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312)228-6850.

24-28, American Association Neurological Surgeons Annual Meeting, Toronto, Ontario, contact: American Association Neurological Surgeons, 22 S. Washington, Suite 100, Park Ridge, IL 60068 (312)692-9500.

OTHER MEETINGS

April

6-7, Southeastern Michigan Medical Expo 88: Quality Medicine of the 90s, Wayne County Medical Society, contact: Wayne County Medical Society Service Bureau, Inc., 1010 Antietam Road, Detroit 48207 (313)567-1640.

13, New Future for the Blues, Oakland County Medical Society, contact: Mary Sue Meyer, Executive Director, 346 Park Street, Birmingham 48009 (517)790-2665.

25-26, Twelfth Annual Conference of the Michigan Association for Infant Mental Health, Ann Arbor, contact: Thomas Horner, PhD, Child and Adolescent Psychiatric Hospital, University of Michigan Medical Center, Ann Arbor 48109 (313)764-5304.

CLASSIFIED

The rate for classified advertising in *Michigan Medicine* is 80 cents per word, with a minimum charge of $40.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

MEDICAL ADMINISTRATIVE ASSISTANT, 9 to 5, rotate Saturdays 9-12. 40 hours per week. $8.00 per hour plus overtime. Duties: To interview patients, take medical history etc in their native languages mainly Indian dialects (Urdu, Punjabi, Sindhi, Gujrati, and Marathi), prepare patients for doctors, answer inquires regarding reports etc. from companies and patients. Must be fluent in reading and writing in the above Indian dialects, as well as English. High school graduate, experience in medical office required. Employer paid ad. Resumes: 7310 Woodward Ave, Rm. 415, Detroit, MI 48202. Reference –76587.

MICHIGAN, ANN ARBOR-DETROIT AREA: Looking for career-oriented emergency physicians board certified/prepared in emergency medicine, internal medicine, surgery or family practice. Directorships with stipends available. Excellent compensation including malpractice insurance. Contact: Emergency Consultants, Inc., One Windemere Place, Room 23, Petoskey, MI 49770; 1-800-253-7092 or in Michigan 1-800-632-9650.

PEDIATRICS Marshfield Clinic, a 250-physician, multispecialty private group practice, is seeking a board-certified or eligible general pediatrician to join ts expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people ocated in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent o a 110-bed JCAH-accredited hospital. Competitive alary and fringe benefit package. Send curriculum vitae and references to: Mr. David Draves, Director, Regional Development, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449. Or you may call collect at (715)387-5376.

GENERAL SURGEON Three-man surgical group ooking for an associate. Candidates should be able o do general and vascular surgery and have additional training or experience in endoscopy. Michigan community of 37,000 with excellent schools, ecreational opportunities and cultural activities. Modern 300-bed hospital with full range of specialty ervices. Please reply to: *Michigan Medicine*, 120 W. Saginaw, Box 120, East Lansing, MI 48826-0950.

MMEDIATE OPENING Board-certified or eligible family practitioners. Expanding two-doctor practice. New multi-physician office building connected with community hospital. Suburban mid-Michigan. Contract with salary, leading to ownership if desired. Respond with CV to J. M. Grost, MD, 901 S. Oakland Street. St. Johns, MI 48879. Telephone (517)224-2338 or (517)669-3924.

FAMILY PRACTICE, nine-to-five, Northern Detroit Suburbs. No inpatient work unless desired. Scheduled office visits. Please send your C.V. to: Action Sell Associates, P.O. Box 832, Dearborn, MI 48121.

GREEN BAY, WISCONSIN 28-physician multispecialty group seeking BC/BE physicians in the following specialties: family practice, pulmonology, pediatrics, ENT and anesthesiology. Green Bay is a progressive community with an easy lifestyle, ample outdoor activities, excellent schools and cultural activities. The clinic offers competitive salary and excellent fringe benefits. Please send CV to: P.M. Kindrachuk, Administrator, West Side Clinic, S.C., Post Office Box 19070, Green Bay, WI 54307-9070.

EMERGENCY MEDICINE For Emergency physician who possesses excellent clinical and trauma skills within a group of 7 emergency room physicians located in beautiful northwest Wisconsin area. Please send C.V. to: Dr. M. Jaghlit, 900 W. Clairemont Ave., Eau Claire, WI 54701, or call (715) 839-4404.

KALAMAZOO Sixth family physician for dynamic comprehensive service with two (suburban and central city) office sites in a socio-economically diverse community. Full salary and fringes. Contact: Steve Pollens, MD, 117 West Paterson Street, Kalamazoo, Michigan 49007 or call (616)349-2641.

INTERNIST BE/BC To join two young internists in growing practice in Michigan's beautiful Upper Peninsula. New local hospital. Campus for Michigan State University Medical School. Community of 15,000. Send C.V. or call: Doctors Spender and Kuehnl, 218 South 10th Street, Escanaba, 49829. (906)786-1563.

FULL TIME, PART TIME AND LOCUM TENENS GPs, PPS and Emergency Physicians needed to staff a network of convenience medical care centers located in Bay City, Saginaw, Midland and Mt. Pleasant, Michigan. Flexible hours and attractive compensation packages. Send CV to, or contact Euclid Medical Group, PC, 1420 Center Avenue, Bay City 48708, (517)892-1199.

FAMILY PRACTITIONER or internist. Full or part time. Maybe semi-retired for physicians office in the Southfield, Lathrup area. Call Richard Corey, Administrator (313)557-5155.

FAMILY PRACTITIONER AND INTERNAL MEDICINE SPECIALISTS to join seven-doctor Family Practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well-equipped 77-bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First-year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact: John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

OB/GYN BOARD CERTIFIED or eligible, to join highly-progressive, rapidly-growing practice. Normal- and high-risk obstetrics emphasized along with highest levels of infertility care (microsurgery, GIFT, IVF, laparoscopic laser surgery), as well as extensive gynecology and surgery practice. Easy lake country or Milwaukee suburban living. Salary and guarantees to meet your needs with opportunity for partnership in one year. Available July 1988, or earlier, Contact: Matt Meyer, MD, Women's Health Care, S.C./Milwaukee Regional Fertility Center, 426 W. Main Street Waukesha, Wisconsin 53186, 414-549-1333.

INTERNIST, OB/GYN AND GENERAL PRACTICE PHYSICIANS: Immediate opening in a busy, established practice, located in the thumb of Michigan, about 100 miles from Detroit. Excellent schools, comfortable lifestyle with many opportunities for outdoor recreation. Competitive salary with all practice expenses paid, plus fringe benefits. Shareholder status available after first year. Reply to: Pigeon Clinic, PC, 7293 Michigan Avenue, Pigeon 48755 or call (517)453-3221.

INDIANA 50 miles from downtown Chicago. Thirty-five physician, multispecialty group located in northwest Indiana (pop. 60,000) is seeking second orthopaedic surgeon. With a service population over 110,000, this community is situated on the shores of Lake Michigan and offers exceptional recreational activities. The clinic houses its own X-ray laboratory, audiology, physical therapy, surgery, and ER. Excellent compensation and benefit package. Call or write Jean Ecos, 250 Regency Court, Waukesha, WI 53186. 1-800-338-7170 or 1-414-785-6500 (collect).

UROLOGIST One hour from Chicago's loop. Progressive 35-physician, multispecialty group in northern Indiana (pop. 60,000) seeking energetic, highly-skilled urologist. Unlimited recreational and cultural opportunities. Guarantee and excellent benefit package. Call or write: George Ivekich, 250 Regency Court, Waukesha, WI 53186. 1-800-338-7107 or 1-414-785-6500 (collect). No costs or obligations involved.

INDUSTRIAL MEDICINE GROUP seeking four physicians interested in practicing comprehensive health care in a stable correctional health setting. Enjoy the full spectrum of general medicine in a protected environment. Quiescent rural and cultural urban positions available. Controlled hours and administrative duties. Liberal salary and benefits. For further information please send current C.V. to: M. Sorenson, Westmound Clinics, 683 Westmound Drive, Waukesha, WI 53186, (414) 544-1300.

Continued on next page

CLASSIFIED/Continued

DETROIT SUBURBAN extended-hour family practice and industrial medical clinic needs licensed MD. Internal medicine, emergency room and family practice, with minor surgery experience will be considered. Part- and full-time position available. Salary plus excellent incentive bonus. Send C.V. to: S. L. Kiwak, Administrator, 1500 Eureka Road, Wyandotte, MI 48192.

FAMILY PRACTICE OPPORTUNITY An exceptional JCAH 85-bed community hospital and its medical staff are searching for several primary care physicians to become part of our growing medical community. Excellent hospital facilities and equipment. Comfortable country life-style less than an hour from Indianapolis. Favorable malpractice climate. Several exceptional existing practice opportunities. For additional information, please submit a current resume in confidence to: Executive Director, Putnam County Hospital, 1542 S. Bloomington Street, Greencastle, IN 46135. (313)653-2178.

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THANKS TO OUR ADVERTISERS

Advanced Medical & Research . . . 173
American Cancer Society 157
American Lung Association 162
American Medical Association 140, 149
Ayerst 127-130
Bennethum Computer Systems . . . 160
Blue Cross & Blue Shield 143
Campbell Labs 169
Ciba-Geigy 153-154
Current Concepts Seminars 162
Family Practice Recertification . . . 161
Group Health Inc. 172
Henry Ford Hospital 150
Hospital & Health Services Credit Union 171
IRS 148
Key Pharmaceutical 141, 142
Laboratory of Clinical Medicine . . 145
Eli Lilly 166
Maternal Health Conference . . . . . IFC
M-Labs 151
Manufacturers Bank 119
Marion Labs 164-165
MDPAC 123
Medical Billing Service 139
Methodist Hospital of Indiana 170
MI Department of Corrections . . . 176
MI Department of Public Health . 164
MI Health Billing & Collection Service 131
MPMLC 163
MSMS Impaired Physicians 159
MSMS Physician Legislative Network 167
Palisades Pharmaceutical 149
Physician Placement Service 151
Physician Service Group 135
POL Consultants 172
PICOM 133
Roche . . . . IBC, BC
Stratton-Cheeseman 175
Smith, Kline, & French 147
Sunnybrook Hospital 174
University of Michigan 157
USAF 138
Wayne County Medical Society . . . 137
Wayne State Alumni 134

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Take the lead in Medicare change

By Carl A. Gagliardi, MD

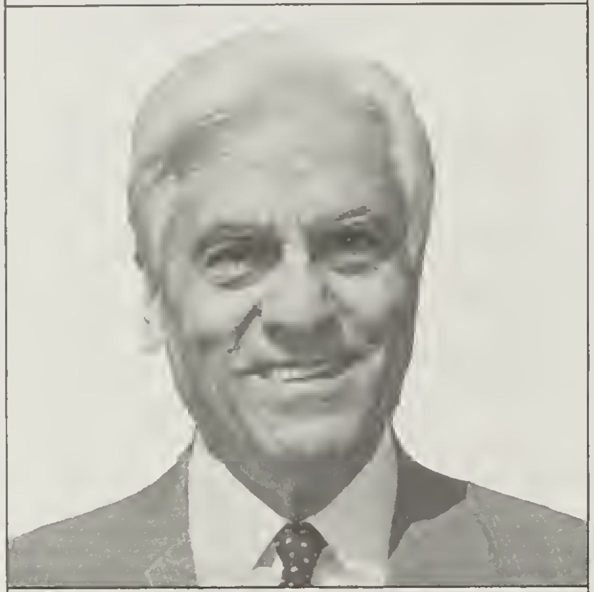
Look at these snippets gleaned from recent newspaper articles about Medicare:

- "Today four taxpayers finance the Medicare costs of each beneficiary, but that ratio will steadily decline and drop to two-to-one by the middle of the next century."
- "Unless significant changes are made, the Medicare Part A Trust Fund reserves will be totally exhausted by 2002 and the program will be about $1 trillion in debt by 2020, according to current Social Security Administration projections."
- "In the draft budget now under consideration, the Administration is eyeing the reduction of about $1.35 billion in fiscal year 1989 Medicare outlays beyond the 1988 and 1989 savings already accomplished."

I don't have to tell you, Medicare has become a nightmare. It's like the old home you want to remodel into a palace; but every time you take off one rotten board you find two more that need replacing. The job might be easier and cheaper if you started over on new footings.

Surveying the landscape, digging in and putting up a new foundation, however, is not something in which Congress is particularly skilled. Nor, for that matter, is it something in which Congress is particularly interested. Certainly, many individual members of Congress are well intentioned, but without constituent pressure behind them, attempts at reform are futile.

Doctor Gagliardi is 1987-88 MSMS president.


Carl A. Gagliard, MD

As members of organized medicine, we have an obligation to help Congress act. The AMA has made known its goals for Medicare, including;

- maintaining access to affordable, high quality care for the elderly;
- altering the existing flawed financial approaches by establishing a prefunded program, and,
- providing an equitable means testing mechanism by applying an income-related deductible.

But without continual reinforcement from individual physicians in organized medicine from across the country, Congress will not act.

Your representatives and senators must hear from you that current Medicare regulations are a Gordian knot at best; that most of your Medicare patients must call to get an explanation after reading their "Explanation of Benefits" form; that Medicare payments really do not adequately reimburse you for your time and service; that the entire system needs to be razed, not remodeled piecemeal.

If there is one thing I have learned during my years in organized medicine, it is the truth in the "squeaky wheel" adage.

This issue of *Michigan Medicine* highlights recent Medicare changes. Please take the time to read this month's special report, beginning on page 114, to bring yourself up-to-date. Then talk to your patients.

Congress is the only entity that can change the Medicare system. And we and our patients are the only ones who can squeak loud enough to make our federal legislators respond.

We are the only ones who can say what physicians encounter on a daily basis under Medicare. Our patients are the only ones who can say what they encounter on a daily basis under Medicare.

I urge you to take a proactive stance on Medicare. Write to your representatives and senators. Educate them. Make them aware. Let them know you are watching their votes.

Talk with your patients. Ask them to write Congress. Talk to community groups in your area. Contact the AARP.

Take the lead in a chorus for change. □

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Special Section: MSMS Annual Report

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Special Report

From the Board of Directors and officers to the committee members and staff, many people are responsible for making MSMS what it is today; a professional, forward-thinking organization which represents more than 11,000 physicians throughout the state. Replacing this month's special report is **the 1987 MSMS Annual Report.** Included in this 12-page report is a letter to the membership from MSMS Executive Director William E. Madigan; photos and short biographies of MSMS officers and Board members; a list of MSMS Committees and chairpersons; a review of MSMS activities and major accomplishments during the past year; a financial statement; and a list of "Whom to Call" at MSMS. We hope MSMS members will find this information enlightening and useful. 213

Features

Reporting Child Abuse
An examination of "whistle blower protection" and "physician responsibility" — By Stephen M. Gaus 191

Health Policy Agenda meeting recap
A photo feature 194

MSMS receives AMA 1987 Membership Award
A photo feature 198

MSMS members "lost"
The MSMS Membership Department is currently updating its files and needs help locating some "lost" members. 212

MSMS credit card collection program offers members state-of-the-art service 234

Departments

In my opinion
"A valiant effort"
By Kenneth E. Rowe, MD, MPH 186
Letters 187
Medical Newsfronts 205
Deaths 210
Physicians in the news 226
Category I courses 239
Meetings 242
Classified 246
Ad index 247
President's page
Most satisfying years
By Carl A. Gagliardi, MD 248

On the cover: MSMS Board of Directors and Officers.

In next month's issue of *Michigan Medicine:* Quality of care issues.

Cover photo by Michael J. Schimpf.

IN MY OPINION

A valiant effort

By Kenneth E. Rowe, MD, MPH

Throughout history health care professionals have handled communicable disease by vaccine development, antibiotic treatment, quarantine and education. None of the major infectious diseases has been controlled without antibiotics or vaccines or improved sanitation.

We are now faced with a new fatal disease caused by a virus for which we have no vaccine or antiviral drug. We are left with education as our only means of controlling the spread of AIDS.

Doctor Rowe

It is reassuring to see the great efforts MSMS is making to help educate Michigan physicians and other health care workers about AIDS, such as the establishment of a statewide **AIDS Speakers Bureau** and an **AIDS Telephone Information Network**, both of which are funded by the Michigan Department of Public Health for professional education.

Regular MSMS meetings, including the Annual Scientific Meeting, the Maternal and Perinatal Health Conference and the Public Affairs Leadership Conference, have featured sessions on AIDS. "AIDS Update," an informational brochure for the public produced by MSMS, has been widely distributed. In addition, members of the MSMS Auxiliary have been active in sponsoring educational forums on AIDS around the state. (An 11-page special report in the February issue of *Michigan Medicine* discusses in detail how MSMS is "taking the lead" on AIDS education.)

It also is reassuring to see the great efforts the Michigan Department of Public Health and hundreds of dedicated doctors, researchers and other scientists around the state are making to control the AIDS problem.

I, like many of you, have spent

Continued on page 200

Doctor Rowe is a member of the MSMS Committee on Publications.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserves the right to accept or reject advertising copy. Products and services advertised in *Michigan Medicine* are neither endorsed nor warranted by MSMS.

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Culham case not the first of its kind

When I submitted a discussion of the Culham case from Oakland County on court-approved removal of a respirator from a competent patient (*Michigan Medicine*, March 1988 issue), I assumed, as did the judge and attorney, that that was the first case of its kind in a Michigan court.

By coincidence, an article published the same month as the Culham decision revealed an earlier Michigan case from 1984, in which the court file was suppressed at the family's request to avoid publicity.

With the later consent of the family, Frederick M. Maynard, MD, and Andrew S. Muth, JD, of the University of Michigan Medical Center, published a case report ("The Choice to End Life as a Ventilator dependent Quadriplegic," *Arch Phys Med Rehabil* 68:862-864, 1987). Through the courtesy of Doctor Maynard and Mr. Muth, I also obtained a copy of the court order and transcript of the hearing, though I will here use no names.

Briefly, the case involved a 19-year-old male who sustained C5 quadriplegic following a diving accident two years previously. After eight months of hospital rehabilitation, he was discharged home to the care of his parents, still dependent upon a mechanical ventilator. Despite aggressive home care with special equip-

Continued on page 196

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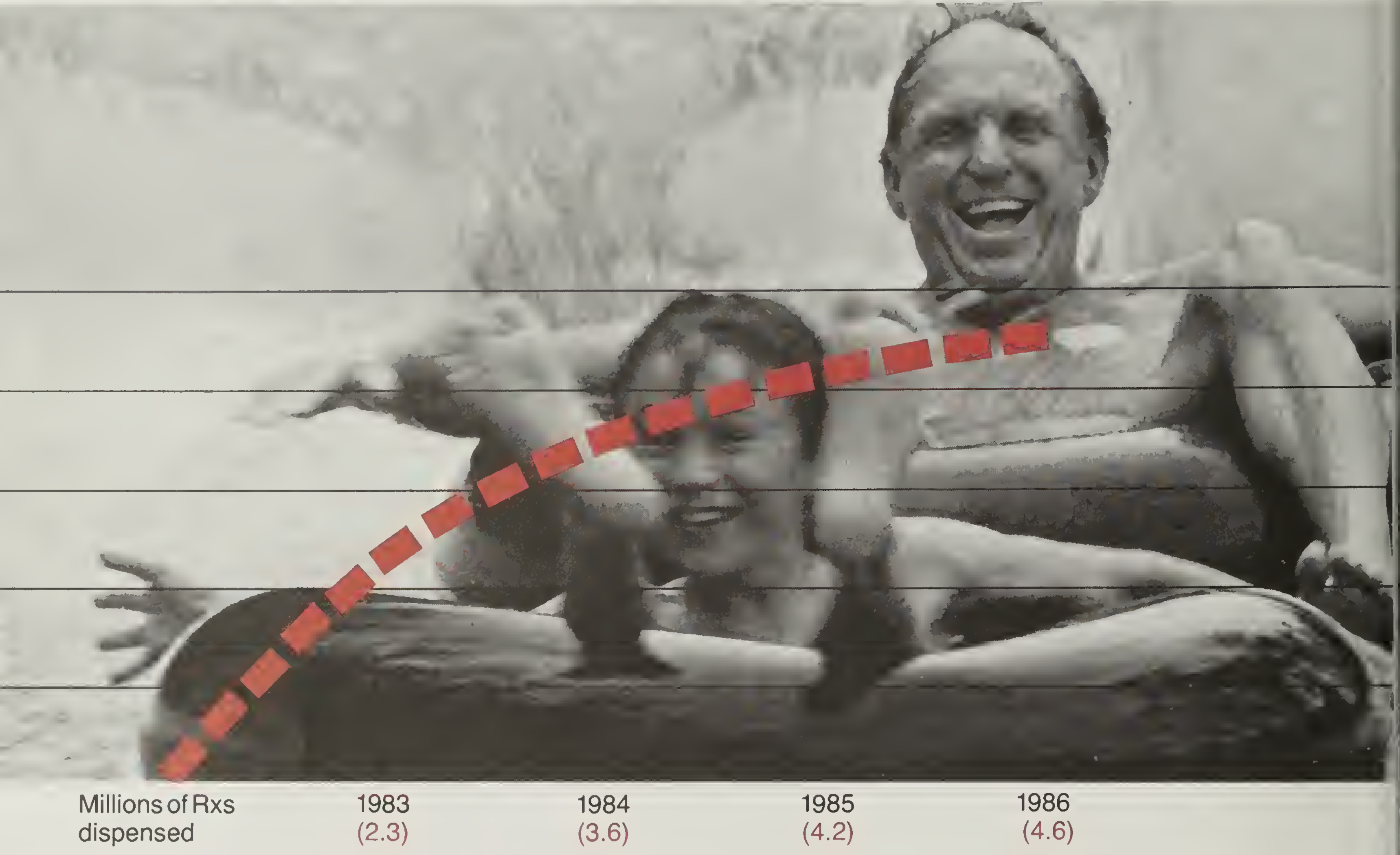

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Reporting child abuse

"Whistle blower protection" and physician responsibility

By Stephan M. Gaus

Synopsis

Michigan's "Child Protection Law" requires physicians to report "suspected" child abuse; holds physicians civilly liable for subsequent injuries to children where child abuse is suspected and not reported; and provides physicians "whistle blower's" protection from civil liability for reporting suspected child abuse.

A client of mine recently called with a question arising out of the following facts. A nine-year-old boy, the product of a broken home where both parents had remarried, was in to see him. He had suspected the child was being beaten by his stepfather. The father had custody and the child would visit the mother and stepfather under routine court orders. The doctor suspected child abuse, but feared he would be unable to substantiate the claim medically. He told the boy's father and stepmother to return to the office as soon as possible if another suspected abuse occurred.

Several weeks later the boy's father appeared at the office with the child on a Monday morning following visitation. The child had been severely beaten and had suffered cuts on his lips and the loosening of teeth. The child reported being hit with a stick and described it to the doctor in detail. The doctor related that he believed the child implicitly. He took pictures and made a thorough examination, being sure to chart all findings. He then called the Department of Social Services who immediately intervened.

Within a few days the boy's mother called the doctor's office and threatened to sue him "for harassment." He felt he had made a proper reporting. He wondered two things: could he really be sued? And, would his medical malpractice insurance policy cover the claim?

The author is an attorney with Smith & Brooker, P.C., Bay City.

"When the professional has 'reasonable cause to suspect child abuse or neglect' an oral report must be made either in person or by telephone. It must be immediate."

The Michigan Statute[1] was created to encourage the reporting of suspected child abuse. The occurrence of child abuse presents a classic moral dilemma in medicine. These are some of the issues the physician faces. What constitutes abuse? What is needed to prove abuse in court? What liability does a doctor face in the event that he is wrong about a suspected abuse? What about patient/physician privilege?

As a practical matter it was believed that many cases of suspected child abuse went unreported because of fears of recrimination and the doctor's fear of losing time from his practice to the court system. In passing this act the legislature provided answers for several dilemmas facing the physician under these circumstances.

Here are some of the relevant provisions of the act.

Who must report: A physician, coroner, dentist, medical examiner, nurse, a person licensed to provide emergency care, an audiologist (and other non-medical professionals) must make an *immediate oral report*.

When to report: When the professional has "reasonable cause to suspect child abuse or neglect" an oral report must be made either in person or by telephone. It must be "immediate." It can be made through office personnel, but the better practice would be to report personally to control the flow of information.

Written report: "Within 72 hours after making the oral report" the professional must file a written report. If the reporting comes from a hospital, agency or school, a copy must be given to the administrator, who also has responsibility to file a report.

What to report: The report *must* contain the name of the child, a description of the abuse or neglect and *should* contain the names and addresses of the child's

Continued on next page

CHILD ABUSE/Continued

parents or guardians, the names of the persons with whom the child resides and the child's age. Any additional information that is relevant should be given. This completes and satisfies the reporting requirements.

What constitutes abuse: The statute defines abuse as "harm or threatened harm to a child's health or welfare by a person responsible for the child's health or welfare which occurs through non-accidental physical or mental injury; sexual abuse; sexual exploitation; or maltreatment. The standard is to make a report when there is "reasonable cause" to "suspect" child abuse. Under the act, pregnancy of a child less than 12 years of age or the presence of venereal disease in a child who is over one month of age, but less than 12 years old, is deemed to be "reasonable cause."

What constitutes child neglect: The failure to provide for a child's health or welfare by failing to provide adequate food, clothing, shelter or medical care. The act specifically includes as abuse the use of children in child pornography.

What happens to the child: If the child's health or welfare would be endangered by release back to the parents, the Department of Social Services is given the right to immediately detain the child in temporary protective custody. The determination that the child is endangered is left to the physician.

Scope of examination: If child abuse is suspected, the physician shall make necessary examinations, including x-rays, photographs, lab studies and other pertinent studies. The results of all tests *must* be reported.

Failure to report: The failure to report suspected child abuse is a misdemeanor. Although no cases appear to have been prosecuted in Michigan, the law is there waiting for the proper circumstances.

More importantly, a doctor who fails to report suspected child abuse is "civilly liable for damages" proximately caused by the failure. In other words, if a child is brought to the doctor and child abuse is suspected, and not reported, the doctor is liable for all subsequent injuries that the child receives as a result of child abuse. This places a great responsibility upon the privilege of medical practice.

The reporting is itself confidential. Unauthorized disclosure of a reported child abuse also constitutes a misdemeanor and also creates civil liability for the wrongful dissemination. The act does not give protection, however, to persons who "knowingly and maliciously make a false report."

Whistle blower protection: Section 5 of the act[2] makes the identity of a reporting person confidential. It also creates immunity from civil or criminal liability for a person making a report "in good faith." To the further protection of physicians, the act of reporting is presumed to be made in good faith. In order to overcome this, a party attempting to sue a doctor would have to show by "a preponderance of the evidence" that the reporting was made in bad faith or with malicious intent.

Insurance coverage: One of my client's two questions related to

HB 4157 would expand reporting requirements of suspected child abuse

HB 4157, currently pending before the Michigan Legislature, would amend the state's Child Protection Law to define child abuse, sexual abuse, and sexual exploitation as acts which could involve *any* person and not just those responsible for the child's health or welfare.

Under the bill, written reports of child abuse or neglect would have to contain the identity of the person responsible for the abuse or neglect as well as other pertinent information already detailed in the act.

When the Department of Social Services received written report of suspected child abuse allegedly caused by a person not responsible for the child's health or welfare, the department would be required to provide a copy to the prosecuting attorney of the counties in which the child suspected of being abused resided and was found.

The MSMS Board of Directors, at their March 2 meeting, supported the concept of HB 4157.

insurance coverage. He wanted to know if his policy would indemnify him and whether the insurance company would provide a defense to the harassment claim brought by the mother. He was unaware that there is a potential lawsuit against him for negligently failing to report a suspected neglect during his earlier visits. All three issues are important.

Generalizations to such questions are risky. But I feel that a few can be made with some confidence. The act of failing to report suspected child abuse is both a misdemeanor crime and a failure to meet a standard of care imposed upon a doctor by State statute. It can be a wilful act and it can be a negligent act. Most insurance policies afford coverage for intentional or wilful acts. If the act is strictly negligent, the insurance company is probably obligated to defend and indemnify, though most insurance companies will be tempted to defend under a "reservation of rights letter."[3] If there is a suggestion that the action of the doctor is wilful or intentional, a reservation of rights letter in almost certain. In any case, an insurance company would be foolish not to provide a defense until the dispute over the provisions of the policy is concluded. In short, the defense of a suit against a doctor for failure to report suspected child abuse should be provided by the insurance carrier and coverage will probably be at issue.

The same rationale follows for a suit based upon a reporting of suspected child abuse. If the reporting was made maliciously or falsely, then the carrier will defend, but under reservation of rights, until their duties are determined by a court. If the reporting was made in good faith, the policy should cover.

In summary: A physician and his staff must be on the alert for child abuse. Physicians working in emergency room settings must be on even greater alert. The office physician often has a greater rapport with a patient than the emergency room doctor. Emergency room staff must be able to read between the lines in the some cases.

When the physician has "reasonable cause" to "suspect" child abuse a reporting *must* be made. There is immunity for a "good faith" reporting. There is no immunity for failing to make a reporting when reasonable cause exists. Therefore, when in doubt, report. That reporting will protect the physician for a claim by the child for subsequent child abuse.

It is now both the moral and legal responsibility of a physician to report suspected child abuse. ☐

Footnotes

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[1] MCLA 722.621 et seq., Public Act 1975, No. 238, effective October 1, 1975.

[2] MCLA 722.625

[3] This device allows the insurer to defend the case without waiving any policy defenses or exclusions it may have.

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Health Policy Agenda discussed

Diane B. McCarthy, chair of the Health Policy Agenda Implementation Committee, discussed the HPA's proposed Patient Compensation Demonstration Project at an introductory meeting held in December at Kellogg Center in East Lansing. The proposed project, if implemented, would provide an alternative to the tort system of resolving patient injury disputes.

Robert E. Paxton, MD, chairman of the MSMS Board of Directors, opened the meeting and specifically addressed the system of patient compensation in Michigan and why MSMS became interested in HPA's proposed project.

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ment to provide for mobility and written communication, he expressed desires to end his life of dependence and began working with legal counsel to avoid legal risks for his parents were they to turn off the respirator at his request.

Approximately one year after discussions began, the circuit court of Washtenaw County heard the patient's petition. The patient himself was able to testify in court by brief sentences; his parents also appeared to reinforce his wishes and his consistent expression of them. A psychiatrist testified that the patient was competent and suffered from no mental illness.

The judge ruled that the patient's decision was rational and considered, and that in the face of this decision, the state could have no overriding interest in prolonging life, especially given the intrusiveness and pain associated with continued treatment, and the absent prognosis for future recovery. He ordered that the patient had the right to refuse any medical treatment, including the respirator.

While the hearing was, technically, held in open court, it was scheduled late on a Friday afternoon so as to avoid the publicity that the family feared.

Two weeks after the judge's ruling, the patient made his final decision to terminate treatment, and he died peacefully after his father turned off the ventilator.

A review of this case and the Culham decision of 1987 shows similar reasoning, except that in the latter case, Judge Breck was able to refer to court decisions in other states, and published guidelines for terminal care, that had not been available in 1984.

It is noteworthy that at least two Michigan lower courts have now approved withdrawal of life-sustaining treatment at the patient's and family's request. The Ann Arbor experience also makes one wonder whether some other decisions exist which have not yet come to public attention.

Howard Brody, MD
Council President
Medical Ethics Resource
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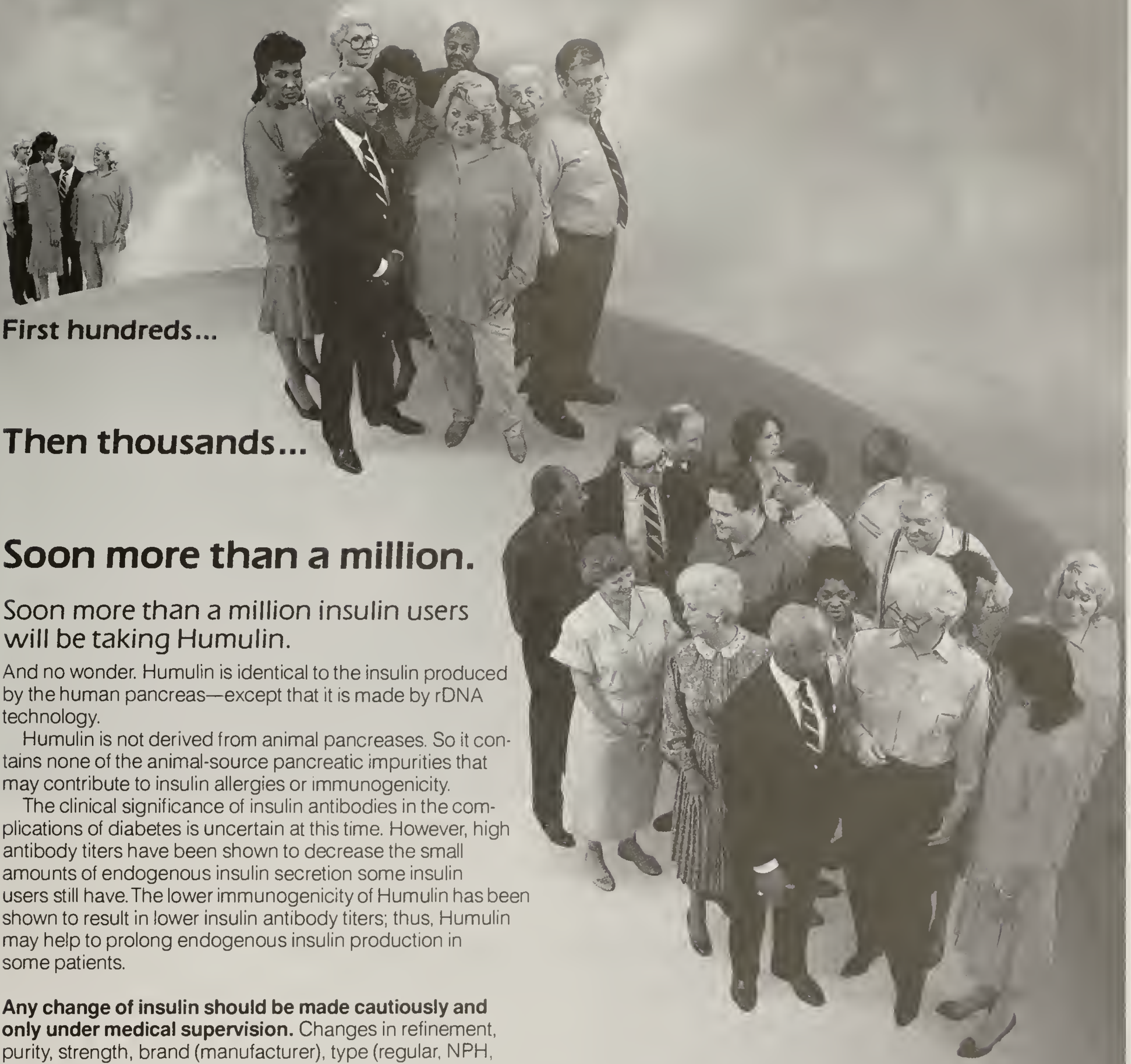

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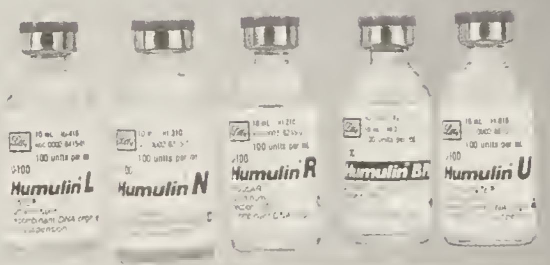

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MSMS receives 1987 AMA Membership Award

MSMS recently received the 1987 Membership Award from the American Medical Association for "exceeding its third consecutive prior year" in AMA member recruitment. Carl A. Gagliardi, MD, MSMS president, (center) accepted the award on behalf of MSMS from William Hotchkiss, MD, (left) AMA president. Also present was Robert E. Paxton, MD, chairman of the MSMS Board of Directors.

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IN MY OPINION/Continued

many hours talking to groups on what AIDS is, and how it can be prevented. Will we succeed in this valiant effort?

Based on our limited success in changing behavior to control drug abuse, smoking, dietary excesses and a number of other problems that would be eliminated or lessened if people used information or technologies available, I tend to be pessimistic occasionally.

Given the alternatives to our educational efforts, we must succeed in this valiant endeavor. While we who are involved in the effort labor, I have a plea to the antiviral drug researchers and vaccine developers:

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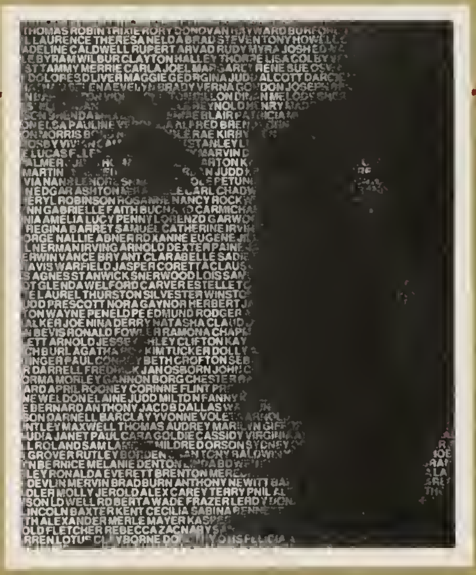

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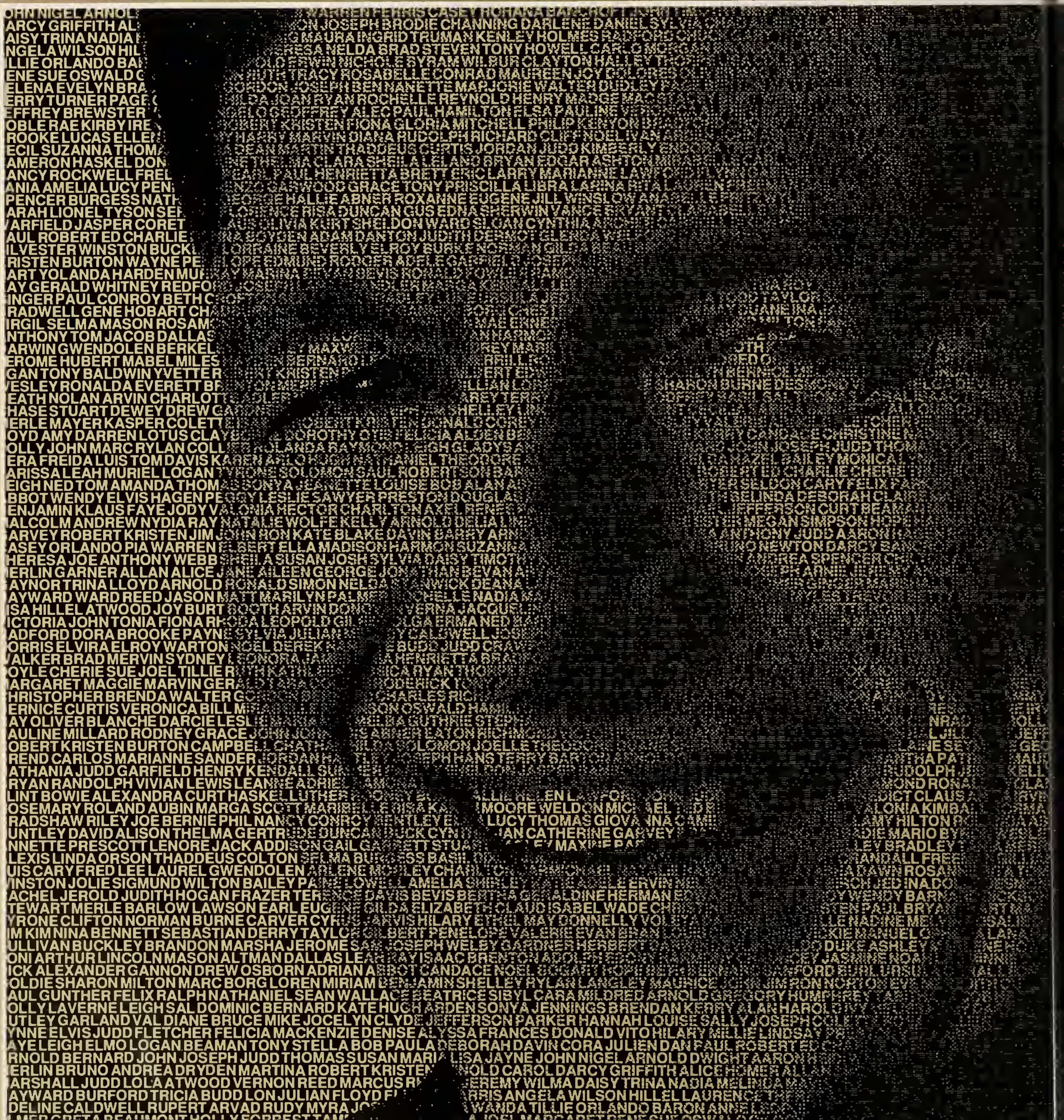

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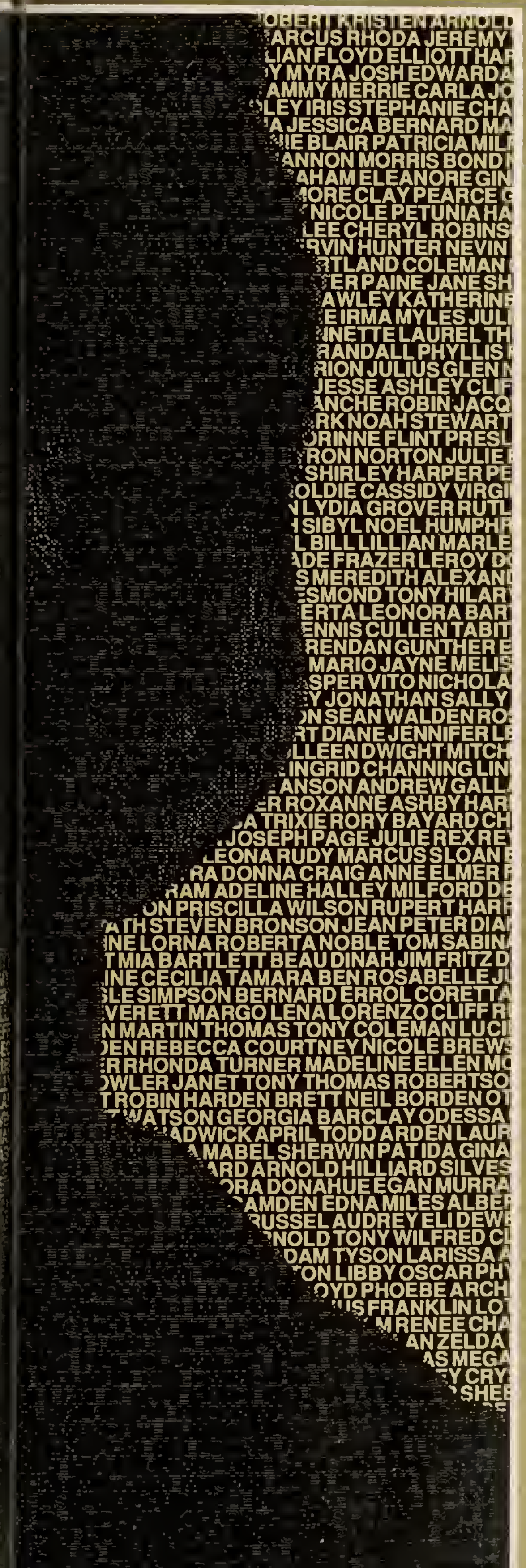

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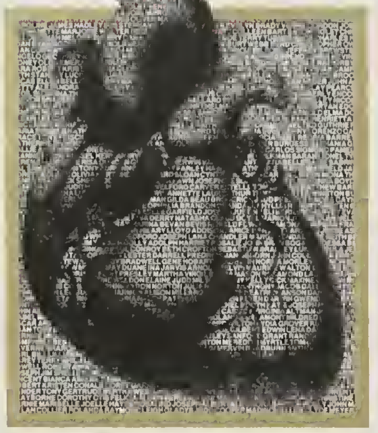

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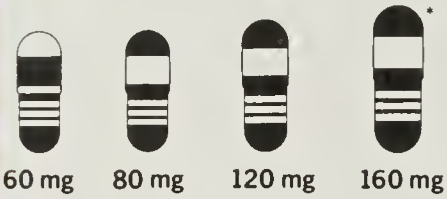

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INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 an reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported i which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a deman pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaire hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be tol that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return o increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart diseas elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The adde catecholamine-blocking action may produce an excessive reduction of resting sympatheti nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardia contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of beta blocker and verapamil has resulted in serious adverse reactions, especially in patients wit severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, *phenobarbitone*, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels o both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly wit propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasin blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animal have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in bot rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in anima studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be use during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised whe INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarel required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time an place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dream appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching an sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, an Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associate with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in sustained-release capsule for administration once daily. If patients are switched from INDERA Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect i maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessar especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL L once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg onc daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage i 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed fo full hypertensive response to a given dosage is variable and may range from a few days to severa weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once dail dosage should be gradually increased at three- to seven-day intervals until optimal response i obtained. Although individual patients may respond at any dosage level, the average optimal dosag appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 m per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (se WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once dail The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually t achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to si weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may b advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited t permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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U-M Arthritis Center expands

A new generation of arthritis research and treatment is in place at the University of Michigan Medical Center under a $6 million research grant from the National Institutes of Health.

The University of Michigan Multipurpose Arthritis Center, which began in 1987, has expanded and reorganized to offer a more multidisciplinary approach to patient care, research and education.

The center is the only one of its kind in the state and just one of 13 across the country.

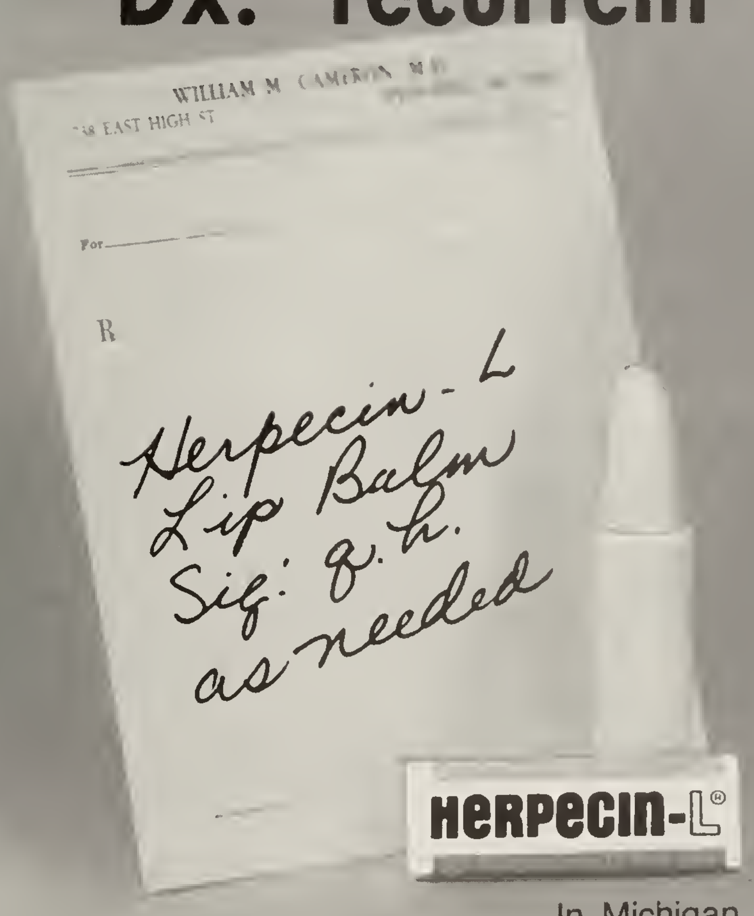
The Multipurpose Arthritis Center draws upon faculty from several departments at the Medical Center, including Internal Medicine, Surgery, Pediatrics, Pathology, Microbiology and Immunology, Biological Chemistry, Genetics and Postgraduate Medicine. Also participating are faculty from the School of Engineering and the School of Public Health.

"Our major thrust is to cross traditional clinical and scientific boundaries and to help establish bridges between the ever-widening clinical-scientific gaps," said William Kelly, MD, professor and chairman of the Department of Internal Medicine and director of the center.

National Yellow Pages study revealing

How many adult consumers who looked in the Yellow Pages

Continued on next page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NEWSFRONTS/Continued

for Physicians & Surgeons actually made a contact? The answer is 78.6 percent, resulting in 430 million purchases, according to the latest results of the National Yellow Pages Service Association (NYPSA) Consumer Usage Study Kit.

The average dollar amount spent on the purchase was $127.00 among those consumers who looked up Physicians & Surgeons in the Yellow Pages and indicated making a purchase, according to the study.

In the NYPSA Usage Study Kit, 24 of the 28 brochures describe a specific product or service category in the Yellow Pages. One brochure ranks over 100 Yellow Pages categories by the annual references made to each category. The other three brochures are the estimated annual references made regarding business, regional and urban/rural usage.

This kit gives national advertisers one of the most effective and powerful usage measurement tools available from any major advertising medium, according to NYPSA. These additional 28 brochures brings the total number to 50 that NYPSA has produced.

Facts and figures regarding the number of Yellow Pages references made annually to the Physicians & Surgeons category, along with ad exposures and purchases are explained.

Founded in 1975, NYPSA is an international advertising trade association created to make it easy to buy and sell National Yel-

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low Pages advertising on both a national and regional basis and to promote the use of the medium as a key ingredient of the national advertiser's major media mix.

A copy of the Physicians & Surgeons brochure can be obtained by sending one dollar to NYPSA Headquarters, 888 W. Big Beaver, Troy, MI 48084.

U-M pathology labs receive accreditation

The pathology laboratories at the University of Michigan Medical Center have been awarded a two-year accreditation by the Commission on Laboratory Accreditation of the College of American Pathologists (CAP).

The accreditation was based on a recent on-site inspection. The Medical Center has one of 3,600 CAP-accredited laboratories nationwide.

Begun in the early 1960s, the CAP program was the first peer-review program for clinical laboratory accreditation. Today the program is one of the few recognized by the federal government as requiring adherence to standards equal to or more stringent than those set by the government.

WSU Neuroscientist receives $850,000 federal grant

A Wayne State University neuroscientist in the department of neurology has received a seven-year, $850,000 federal award to continue her research into the

Continued on next page

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nerve insulation that permits such basic functions as seeing, walking and talking. Damage to this insulation and the cells that manufacture it play a role in multiple sclerosis.

Doctor Joyce A. Benjamins, of Grosse Pointe Woods, received the Senator Jacob K. Javits Neuroscience Investigator Award from the National Institute of Neurological and Communicative Disorders and Stroke. The award provides more than $100,000 each year through 1994.

Doctor Benjamins, who joined Wayne State in 1975, has spent the past 12 years studying oligodendrocytes, the cells in the brain and spinal cord that manufacture components of myelin.

She hopes that through her research into oligodendrocytes she will learn more about how these cells function, and how they are affected in MS patients.

"We hope to find agents that will stimulate the cells to make more of this myelin membrane," she said. "This might suggest applications in humans."

UC MedLabs offers new esoteric testing services

The University of Chicago MedLabs has announced plans to offer area physicians many of the esoteric testing services previously available only to the University of Chicago Hospitals patients.

Under the UC MedLabs name, both non-proprietary testing services and a series of unique test panels developed with the University of Chicago Hospitals Laboratories will be offered.

The objective of this venture is to make the latest and most sophisticated diagnostic tests available to private practice physicians in a more convenient and cost-effective manner.

According to Doctor S. Thomas Shaw, Director of Clinical Laboratories at the University of Chicago Hospitals, "The tests and services being offered by UC MedLabs are not commonly performed in the Chicago area and when needed, are shipped to West Coast laboratories. Out-of-state testing continually lengthens response time, drastically increases cost and rarely promotes physician-to-laboratory consultation on the results. This new service responds to these vital medical issues."☐

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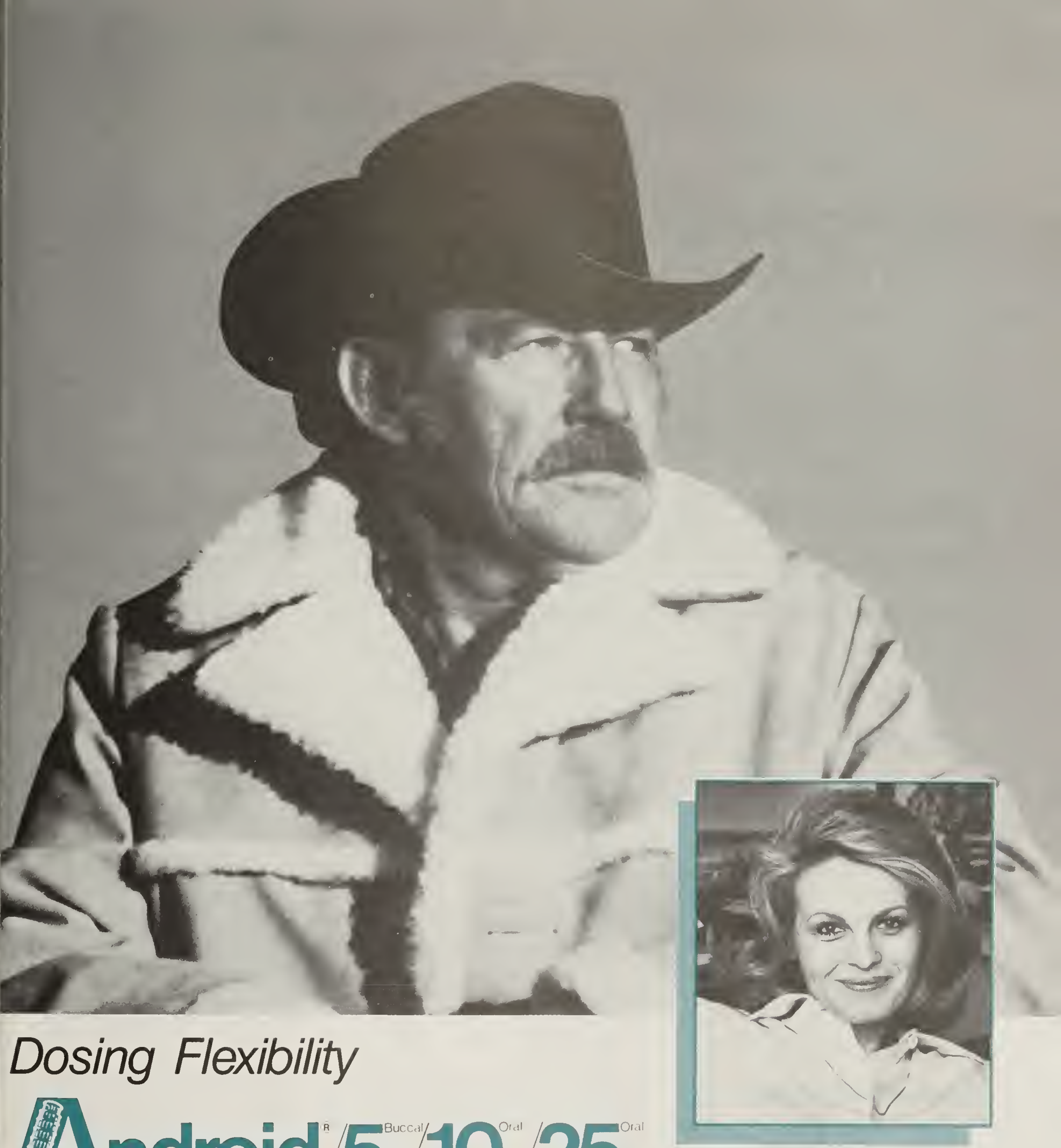

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DEATHS

John N. Asline, MD
Essexville

Doctor Asline died January 23 at the age of 81. He attended Central Michigan University and was graduated from Albion College. Doctor Asline attended Northwestern University Medical School in Chicago and interned at Grace Hospital in Detroit. He was a member of the American Medical Association, and was past-president of the Bay County Medical Society. He also was a member of the surgical staff at the former Mercy and General Hospitals. Doctor Asline served in the Southwest Pacific with the 116th US Army General Hospital during World War II.

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Robert V. Daugharty, MD
Cadillac

Doctor Daugharty died January 29 at the age of 79. He was a graduate of Central Michigan University and a 1938 graduate of Wayne State University Medical School. He practiced in Cadillac from 1941 until his retirement in 1980. He also served as chief of staff at Mercy Hospital. He was a captain in the Army Medical Corps during World War II, stationed in England.

I. Jerome Hauser, MD
West Bloomfield

Doctor Hauser died February 20 at the age of 80. A 1931 graduate of the University of Michigan Medical School, Doctor Hauser was Sinai Hospital Eye, Ear, Nose and Throat Department chief and former chief of staff. He also worked as a professor of otolaryngology at Wayne State University, serving as a professor emeritus until his death. He also served as a lieutenant colonel in the Army Medical Corps during World War II.

Raymond C. Husband, MD
Birmingham

Doctor Husband died February 20 at the age of 71. He was

Continued on page 230

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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The MSMS Membership Department is currently updating its files and needs your help locating the following people:

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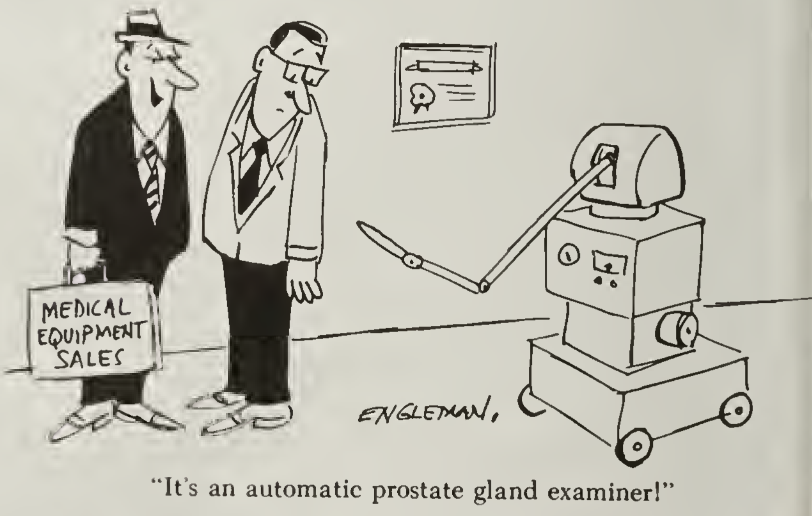
Chippewa County
Charles F. Thompson, MD
Lapeer County
Stanley M. Lynk, MD
Marquette County
John C. Harkin, MD
Wayne County
John C. Carlisle, MD
Esther H. Dale, MD
Charles C. Eades, MD
Perry C. Gittins, MD
Rose E. Herrold-Horton, MD
Harold H. Lampman, MD
David G. Morton, MD
Louis A. Schwartz, MD
John L. Siefert, MD
Walter M. Squires, MD
Lakshmi Sridhar, MD
Harry Weisberg, MD

Anyone who has information on the whereabouts of these people is encouraged to contact Peg Berry at MSMS. □



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MICHIGAN STATE MEDICAL SOCIETY

1987 ANNUAL REPORT

TABLE OF CONTENTS

Letter to Members 3
MSMS 1987-88 Officers 4
MSMS Board of Directors 5, 6, 7
MSMS Committees, Chairmen 7
MSMS Activities 8, 9
Balance Sheet 10
Statement of Revenues and Expenses 11
Whom to Call at MSMS Headquarters 12

Architect Minoru Yamasaki created a building of unusual design and unique construction to house the Michigan State Medical Society. Combining elegance with utility, the structure's timeless style belies its 1959 construction.

The building stands on an elevation surrounded by three-and-one-half acres of beautifully landscaped grounds. Its 31 gracefully curved, 55-foot-long roof vaults of pre-cast concrete rest on 64 vertical columns. The columns and side walls are made of quartz aggregate surface concrete. Nearly 80 percent of the exterior of the building is gray non-glare glass. The main structure is 155 feet long, 46 feet wide, and encloses 20,000 square feet of floor space.

A circular drive off Saginaw Street offers access to the raised terrace extending the full length of the building. The off-center front entrance is recessed and opens into a two-story high reception area.

Behind the building, terraced steps rise from the large parking lot to the main entrance. Sheltered by large trees, the rear of the structure is equally imposing as the front.

LETTER TO MEMBERS

It is an honor and a pleasure to present to you the 1987 Annual Report — the first report of its kind MSMS has produced in several years.

This report is just one example of our solid commitment to informing the membership about the inner workings of MSMS — an organization which can (and is) increasingly being described as progressive, energetic, exciting, action-oriented, and perhaps most importantly, democratic.

Our recent Special House of Delegates meeting, one of only four in the history of MSMS, is a prime example of our commitment to involving the membership in important, crucial and controversial discussions and decisions.

There is no question that MSMS is a physician-run organization. Michigan physicians actively participate through 38 MSMS standing committees, six task forces and three sections. MSMS encourages involvement from rural and urban centers, from young physicians and those more mature, from women physicians and those of all ethnic groups.

Michigan physicians, through the MSMS House of Delegates, Board of Directors, and committees, determine policy and direct organizational resources. Through official publications and as spokesmen for MSMS, members have multiple opportunities to express their opinions, to influence the course of organized medicine and to improve medical care for all Michigan citizens.

Many MSMS members from across the state devote countless hours and immeasurable energy to carry out the missions of MSMS, not the least of which include promoting quality of care, providing medical leadership within the state, and aiding Michigan physicians in maintaining high levels of ethical conduct and standards of practice.

Hundreds of MSMS members have made the choice to help promote the interests of all physicians in Michigan. Among them are 33 officers and Board members, 478 MSMS delegates and alternate delegates, 22 members of the AMA delegation, 438 MSMS committee members, and countless others who contribute advice and ideas.

MSMS is committed to telling you of the contributions of your colleagues working in concert through MSMS activities. This annual report is witness to that pledge. I invite you to study its pages, experience the synergism which exists between MSMS and its leaders, and then make your own commitment to serve through MSMS participation.

William E. Madigan
Executive Director

1987-1988 OFFICERS

Carl A. Gagliardi, MD
President

Frederick W. Bryant, MD
President-Elect

Thomas R. Berglund, MD
Immediate
Past President

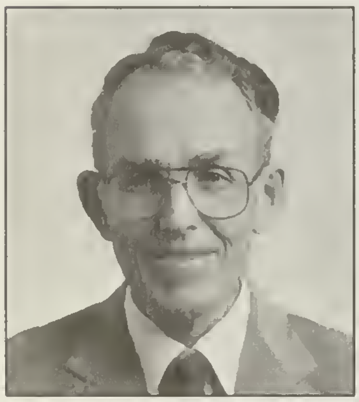
Robert M. Leitch, MD
Secretary

Doctor Gagliardi, *Dearborn pediatrician and medical educator, is past chairman, MSMS Board of Directors. He is chairman, MSMS Professional Liability Task Force. He is a graduate of the Yale University School of Medicine.*

Doctor Bryant, *Royal Oak ophthalmologist, is chairman, MSMS AIDS Provider Education Task Force. A graduate of the University of Michigan Medical School, he is currently a member, American Academy of Ophthalmology.*

Doctor Berglund, *Portage family physician, is past MSMS president and Board chairman. He is past chairman of AMPAC and currently serves as president of the Michigan Physicians Mutual Liability Co. Doctor Berglund is a graduate of the University of Michigan Medical School.*

Doctor Leitch, *Battle Creek general practitioner, is past MSMS president and Board chairman. He served as president, Michigan Physicians Mutual Liability Co. until his retirement in January. He is a graduate, University of Michigan Medical School.*



Leland E. Holly, II, MD
Treasurer

Gerald H. Mandell, MD
Speaker

Robert D. Burton, MD
Vice Speaker

Donald K. Crandall, MD
AMA Delegation
Representative

Doctor Holly, *Muskegon radiologist, is MSMS treasurer. A graduate of the Northwestern University School of Medicine, Doctor Holly serves on the MSMS Board of Managers.*

Doctor Mandell, *Detroit pathologist, is speaker of the MSMS House of Delegates and president of Medical Associations for Risk Management. He is a graduate of Wayne State University School of Medicine.*

Doctor Burton, *Grand Rapids otorhinolaryngologist, is a graduate of the University of Michigan Medical School. In addition to his current role as vice speaker, Doctor Burton currently serves as vice chairman of the Michigan delegation to the AMA.*

Doctor Crandall, *Muskegon general surgeon, is past president of MSMS. A graduate of the University of Michigan Medical School, he is a member, board of directors, Michigan Society of General Surgery. He is chairman of the AMA Council on Medical Service.*

BOARD OF DIRECTORS

Robert E. Paxton, MD
Chairman

Doctor Paxton, *Fremont family physician, has held several MSMS posts, including delegate, chairman of the Ways & Means and Finance committees, and board member of MDPAC. A graduate of the University of Illinois Medical School, Doctor Paxton is a member of the board, Michigan Academy of Family Physicians.*

Frank B. Walker, MD
Vice Chairman

Doctor Walker, *Grosse Pointe Farms pathologist, has been a member of the MSMS Board of Directors since 1980. He is chairman, Michigan Delegation to the AMA, and chairman, AMA Council on Long-Range Planning. A graduate of the Wayne State University School of Medicine, Doctor Walker is treasurer, American Board of Pathology.*

Adelman

Barry

Baumann

Black

Chase

Domzalski

Susan E. Adelman, MD, *Detroit pediatric surgeon, is chair, MSMS-BCBSM Liaison Committee; trustee, Wayne County Medical Society; and an editor,* American Medical News. *She is a graduate of the Wayne State University School of Medicine.*

Jack L. Barry, MD, *Saginaw family practitioner, is chairman, MSMS Finance Committee. A graduate of the Wayne State University School of Medicine, he currently is regional medical director of Health Plus of Michigan.*

Billy Ben Baumann, MD, *Pontiac clinical pathologist, is a past president, Oakland County Medical Society and the Michigan Society of Pathologists, and past chairman, AMA Committee on Allied Health Education and Accreditation. He is a graduate of the Washington University School of Medicine, St. Louis.*

Robert W. Black, MD, *Detroit internist, is chairman, Michigan Health Care Education Research Foundation, Blue Cross/Blue Shield of Michigan trustee, and president, Detroit Academy of Medicine. He received his medical degree from McGill University, Montreal.*

R. Jack Chase, MD, *Grand Rapids internist, is former chairman, MSMS Committee on Cost Containment; board member, MDPAC; and trustee, Butterworth Hospital and Foundation. He is a graduate, U of M Medical School.*

Henry M. Domzalski, MD, *Detroit urologist, is chairman, MSMS Committee on Publications, and member, Wayne County Medical Society Board of Trustees. He received his medical degree from the University of Michigan.*

Dorfman

Duhamel

Lionel E. Dorfman, MD, *Battle Creek urologist, has held a variety of posts with MSMS and other professional organizations including member of the board of directors, MDPAC, and delegate to the MSMS House. He earned his medical degree from the University of Toronto.*

Peter A. Duhamel, MD, *Rochester general surgeon, is chairman, MDPAC, and past chairman, MSMS Hospital Medical Staff Section. A graduate of St. Louis University, Doctor Duhamel is a board member, Greater Rochester Chamber of Commerce.*

Fenton

Hall

James L. Fenton, MD, *Bay City radiologist, is past president, Michigan Board of Medicine. He is a past president, Bay County Medical Society, and a graduate, Wayne State University School of Medicine.*

John W. Hall, MD, *Petoskey urologist, is past chairman, MSMS Committee on Publications, and heads the Board's Committee on Scientific and Educational Affairs. He is a graduate of the University of Michigan Medical School.*

Hammerstrom

Herrington

Carl F. Hammerstrom, MD, *Marquette internist, is former chairman, MSMS Committee on CME Programming. He is a trustee, Michigan Society of Internal Medicine, and American Lung Association of Michigan. He earned his medical degree from Johns Hopkins University.*

Kenneth B. Herrington, MD, *Bad Axe internist, has served as president, Huron County Medical Society, and district director, Michigan Society of Internal Medicine. He is a graduate, University of Michigan Medical School.*

Horsh

McCabe

Richard P. Horsch, MD, *Farmington anesthesiologist, is past president, Wayne County Medical Society, delegate to the MSMS House, and associate editor,* Detroit Medical News. *He is a graduate, Wayne State University School of Medicine.*

W. Peter McCabe, MD, *Grosse Pointe Woods plastic surgeon, has held a variety of posts with MSMS and other professional organizations including vice chairman of the Physicians Insurance Company of Michigan. Doctor McCabe earned his medical degree from Cornell University.*

Moehn

Patterson

Earl G. Moehn, MD, *a Mount Clemens general surgeon, has served as chairman of the MSMS Committee on Constitution and Bylaws. He is a graduate, Wayne State University School of Medicine.*

Fred E. Patterson, MD, *is director of radiology, Foote Memorial Hospital, Jackson. He is former chairman, MSMS Public Affairs/Leadership Conference. He is a graduate, University of Iowa School of Medicine.*

Payne

Rapport

Thomas C. Payne, MD, *Lansing diagnostic radiologist, is former MSMS assistant secretary. He is past MDPAC chairman and former chairman, MSMS Public Relations Committee. He is a graduate, University of Cincinnati School of Medicine.*

Richard L. Rapport, MD, *Flint thoracic surgeon, heads the Board's Health Care Delivery Committee. He is director, BCBSM and PROM. He is a graduate, Wayne State University School of Medicine.*

Rowe

Shearer

Kenneth E. Rowe, MD, *Hancock, is medical director for the Western Upper Peninsula and Dickinson-Iron County Health Departments. He also serves on the Executive Council, Michigan Association for Local Public Health. He is a graduate of the University of Michigan Medical School.*

Marguerite Shearer, MD, *Ann Arbor family physician, is chairman, MSMS Liaison Committee with MPRO. She heads the Board's Legislative Policy Committee. A graduate of the University of Michigan Medical School, she is a director, Michigan Academy of Family Physicians.*

Ulmer

VanGoor

Arthur H. Ulmer, MD, *Grosse Pointe Shores general surgeon, is past president, St. Clair County Medical Society, and Michigan Division, American Cancer Society. He is a graduate of the University of Michigan Medical School.*

Kornelius Van Goor, MD, *Grand Rapids dermatologist, is a member, MSMS Committee on Bioethics. He is a graduate of the University of Maryland School of Medicine.*

Wilson

B. David Wilson, MD, *Kalamazoo allergist, is a member, MDPAC Board of Directors. Doctor Wilson is a graduate, Wayne State University School of Medicine.*

Special guests invited to every MSMS Board of Directors meeting are: **Justin L. Sleight, MD,** *MSMS assistant secretary;* **William B. Jensen, MD,** *representing the MSMS Specialty Society Caucus;* **Edward G. Jankowski, MD,** *representing MSMS Resident Physician Section;* **Gary D. Maynard, MD,** *representing MSMS Hospital Medical Staff Section; and* **John M. O'Brien,** *representing MSMS Medical Student Section.*

MSMS COMMITTEES AND CHAIRMEN

Committee on Aging
James G. O'Brien, MD

Liaison Committee with Michigan Medical Arbitration System
Rhoda M. Powsner, MD

Committee on Awards
Frank B. Walker, MD

Committee on Bioethics
Frederick W. Bryant, MD

Liaison Committee with Blue Cross/Blue Shield of Michigan
Susan E. Adelman, MD

Board of Managers
Leland E. Holly, II, MD

Advisory Committee on Communications and Professional Relations
Richard H. Gascoigne, MD

Committee on Constitution and Bylaws
Robert D. Allaben, MD

Committee on CME Accreditation
Donald J. Aiken, MD

Committee on CME Programming
David R. Rovner, MD

Liaison Committee with Corporate Medical Directors
Richard H. Gascoigne, MD

Steering Committee to Develop a GFMS Section
Busharat Ahmad, MD

Advisory Committee on Health Care Policy
Kenneth J. Ray, MD
Fred E. Patterson, MD

Steering Committee on Program to Assist Impaired Physicians
Henry M. Domzalski, MD

Judicial Commission
Robert P. Lilly, MD

Committee on Maternal and Perinatal Health
Robert W. Dustin, MD

Advisory Committee to the Section of Medical Economics
Jay K. Harness, MD

Medicaid Liaison Committee
Allen F. Turcke, MD
Cecil R. Jonas, MD

Liaison Committee with Medical Assistants
Gordon F. VanOtteren, MD

Committee on Medical Licensure and Discipline
Rhoda M. Powsner, MD

Committee on Membership Recruitment and Retention
Cathy O. Blight, MD

Liaison Committee with Michigan Department of Public Health
E. Joseph Alberding, MD

Michigan Doctors Political Action Committee Board of Directors
Peter A. Duhamel, MD

Michigan State Medical Society/ Michigan Hospital Association Liaison Committee

Liaison Committee with MPRO
Marguerite R. Shearer, MD

Advisory Committee on Office Automation
Frank B. Walker, MD

Planning Committee for Michigan Conference on Maternal and Perinatal Health
Steven M. Donn, MD
Kenneth J. Vanderkolk, MD

Planning Committee for MSMS Annual Scientific Meeting
Rudi Ansbacher, MD

Committee on MSMS Policy Manual
Robert D. Burton, MD

Board of Directors, Physician Service Group, Inc.
Leland E. Holly, II, MD

Committee on Publications
Henry M. Domzalski, MD

Committee on Sports Medicine
Perry W. Greene, Jr., MD

Interpersonal Liaison Committee with State Bar of Michigan

Committee on State Legislation and Regulations
Frederick V. Minkow, MD

Committee of Specialty Society Presidents
Frederick W. Bryant, MD

Committee on Ways and Means
Fred W. Whitehouse, MD

Committee on Concerns of Women Physicians
Dawn E. Springer, MD

MSMS ACTIVITIES

By Carl A. Gagliardi, MD
and
Robert E. Paxton, MD

Carl A. Gagliardi, MD
President

Robert E. Paxton, MD
Chairman of the Board

Professional liability, AIDS education, Medicare reform, physician CME, liaison with government and third-party organizations, member services — all are key areas in which MSMS members are active today.

Michigan physicians place reform of the professional liability system among their top priorities. MSMS leadership, members and staff have been working diligently to resolve the medical liability problem.

MSMS labored for a 1986 legislative package designed to stem the numbers and sizes of lawsuits filed against physicians by patients. We may be seeing the first results of that legislation today.

MSMS legislative goals for 1988 include protection of personal pension assets, and a state-level task force charged with finding ultimate solutions to the dilemma.

Because of its strong presence in the legislative arena, MSMS has been named third most potent statewide lobbying organization.

MSMS has been in the forefront of efforts to seek solutions to the liability system which do not involve reform of the court system. In one of these efforts MSMS has won designation of Michigan as a pilot site for testing a patient injury compensation system as an alternative for medical liability dispute resolution. We also are looking at the AMA Specialty Society at-fault compensation fund, we have formed a new committee with the Michigan Hospital Association to study alternatives to tort and we are continuing to pressure the Governor to appoint a task force to study alternatives to tort as recommended by his factfinder on liability, Robben Fleming.

Such a system was proposed by the Health Policy Agenda for the American People, a five-year effort by 173 participating organizations. The Agenda was initiated by the AMA, and included Michigan physicians' input in key roles.

But there is much more to the MSMS story. Here are some of the highlights of current MSMS programs:

AIDS education

MSMS is the key organization in the state for educating providers about the deadly disease, AIDS. The Michigan Department of Public Health has awarded MSMS $250,000 the past two years to spearhead this important effort. MSMS President-elect Frederick W. Bryant, MD, chairs the MSMS AIDS Provider Education Task Force.

The four-part program includes an AIDS hotline, 1-800-522-0399 (567-0399 in Detroit), which is staffed from 9 am to 2 pm each day, and has a 24-hour answering service.

It includes the MSMS AIDS Speakers Bureau, established in 1987 by trained physicians who are available to address county medical societies, nurses' groups, medical assistants and other health professionals.

The third part is a program to train professionals to develop AIDS information sources among their colleagues.

The fourth part is a set of guidelines for professionals, developed by MSMS and included in infection control procedures established by the Department of Public Health.

Graduates of foreign schools

MSMS strengthens the voice of graduates of foreign medical schools, who will move closer at the 1988 House of Delegates meeting to forming an MSMS section of their own.

The steering committee to develop the new section has published two quarterly newsletters. Members also successfully sought changes in licensure rules which make it possible for foreign school graduates to be licensed by endorsement, and which remove the requirement that they document Board of Medicine approval of their clerkship hospitals.

Liaison for members

MSMS maintains an active liaison with other key state groups, including the State Bar, Michigan Hospital Association, Michigan Association of Osteopathic Physicians and Surgeons, Economic Alliance for Michigan, and Michigan Department of Public Health.

MSMS and the State currently are organizing a joint campaign to encourage more life-giving donations of organs for transplantation, and together are studying the legal aspects of AIDS. With the Hospital Association, MSMS is searching for solutions to the medical liability crisis, and working toward better collection and analysis of health data. Common projects with the Department of Public Health are numerous, highlighted by the MDPH grant to MSMS and AIDS education.

CME for members

During the past year MSMS awarded 12,000 total continuing medical education credits. This figure spotlights the major MSMS function devoted to helping educate members and to improving patient care. In 1987, approximately 1,500 physicians and health professionals attended the MSMS Annual Scientific Meeting, another 800 attended the MSMS-sponsored Michigan Conference on Maternal and Perinatal Health, and another 700 attended additional, jointly-sponsored MSMS Category I conferences.

Third party carriers

MSMS provides help for members dealing with Blue Cross Blue Shield of Michigan and the Michigan Peer Review Organization. With its new liaison committees with both organizations, established in 1987, MSMS speaks for members with a strong voice. The BCBSM Liaison Committee has won the company's cooperation on several procedures changes, including those for grievances, sought by MSMS members. The MPRO Liaison Committee facilitates dispute resolution and provides advice and assistance in resolving problems.

MSMS continues to channel members' concerns and comments regarding Medicare and Medicaid programs.

It's impossible for individuals to have an effect upon our federal government, you think? Don't tell it to MSMS members. In 1987 Michigan physicians joined their voices with those of physicians around the country and made a difference in Medicare policies.

Because of physicians' strongly-voiced objections, the government put off DRGs for physicians' services, and mandatory assignment, and agreed to improve its processes for informing physicians of payment problems.

The vehicles for defeating the government's plans were concurrent House and Senate resolutions against the DRGs and mandatory assignment. Michigan physicians were successful in getting all of the state's congressmen to join the majority of their colleagues who signed the resolutions, thus giving the administration notice it was going too far with its proposed Medicare policies.

The Medicaid Liaison Committee meets on a regular basis with officials of the Michigan Medical Services Administration to express physicians' concerns and suggestions. The MSMS Department of Medical Economics and the Committee on Aging interpret changes and recommendations in federal insurance programs for physicians and federal government alike.

Member services

MSMS handles approximately 500 telephone calls per month on its group health insurance programs hotline. The hotline, a key feature of the MSMS administrative services contract with Blue Cross Blue Shield of Michigan, was established in 1986. It enables members to deal directly with MSMS regarding their group health insurance. The number is 1-800-942-4141.

MSMS' efforts are made with you, the member, in mind. Member benefits and subsidiary services all seek to anticipate and meet your needs. And, knowing the greatest strength lies in unified numbers, MSMS is engaged in an active member recruitment campaign.

The campaign, under way since January, has brought scores of new members into the fold. As each physician joins, the organization's voice becomes stronger.

Expanding resources

With this wide variety of activities and programs under way, MSMS is now a $4,000,000-plus operation. To maintain the organization's vital force and active presence, MSMS officers and managers are ever-vigilant of its resources. One of the fiscal goals is to develop a stronger non-dues base. Currently, 31 percent of total operations are based on income derived from non-dues sources.

To that end, MSMS is engaged in a joint effort with the Michigan Physicians Mutual Liability Company to increase real estate holdings in the booming East Lansing/Okemos/Meridian Township area of mid-Michigan. MSMS and MPMLC are building a 92,150-square foot building on the corner of Hagadorn Street and Saginaw Highway in East Lansing, near MSMS headquarters. On completion (expected late in 1989), half of the building will be occupied by MPMLC, and the rest will be rented. Cost of the building is projected at $7.5 million.

BALANCE SHEET

Michigan State Medical Society **November 30, 198**

Assets	Operating Fund	Capital Reserve Fund	Creative Reserve Fund	Gifts and Endowment Fund	Mortgage Debt Retirement Fund	Total
CURRENT ASSETS:						
Cash	$ 300	$ 237,655				$ 237,9
Short-term investments	527,699	935,500	$492,229	$ 98,516	$ 641	2,054,5
Accounts receivable						
Unconsolidated subsidiaries	15,359					15,3
Advertisers and other	306,907	9,377				316,2
Due from (to) other funds	516,584	(476,658)	(34,926)	(5,000)		—0
Current portion of notes receivable from unconsolidated subsidiaries	30,000					30,0
Accrued interest receivable	54,799	3,023	1,691			59,5
Prepaid expenses	67,480	429				67,9
TOTAL CURRENT ASSETS	$1,519,128	$ 709,326	$458,994	$ 93,516	$ 641	$2,781,6
NOTES RECEIVABLE FROM UNCONSOLIDATED SUBSIDIARIES, less current portion	484,700					484,7
LONG-TERM INVESTMENTS	1,200	151,712		17,313	634,222	804,4
INVESTMENT IN LAND		476,996				476,9
PROPERTY AND EQUIPMENT	2,184,718	36,763				2,221,4
	$4,189,746	$1,374,797	$458,994	$110,829	$634,863	$6,769,2

LIABILITIES AND FUND BALANCES

LIABILITIES AND FUND BALANCES	Operating Fund	Capital Reserve Fund	Creative Reserve Fund	Gifts and Endowment Fund	Mortgage Debt Retirement Fund	Total
CURRENT LIABILITIES:						
Accounts payable	$ 634,651					$ 634,6
Accrued liabilities	48,303					48,3
Prepaid dues	200,019					200,0
Deferred revenue	35,000					35,0
Current portion of long-term debt	23,772					23,7
TOTAL CURRENT LIABILITIES	$ 941,745					$ 941,7
LOSSES OF UNCONSOLIDATED SUBSIDIARIES IN EXCESS OF INVESTMENTS			$421,562			421,5
LONG-TERM DEBT, less current portion	1,441,367					1,441,3
FUND BALANCES	1,806,634	$1,374,797	37,432	$110,829	$634,863	3,964,5
	$4,189,746	$1,374,797	$458,994	$110,829	$634,863	$6,769,2

STATEMENT OF REVENUES AND EXPENSES

Michigan State Medical Society

November 30, 1987

	Operating Fund	Capital Reserve Fund	Creative Reserve Fund	Gifts and Endowment Fund	Mortgage Debt Retirement Fund	Total
REVENUES:						
Dues — membership	$2,408,266					$2,408,266
Dividends and interest	116,072	$ 56,685	$ 35,733	$ 5,390	$67,783	281,663
Michigan Medicine Magazine:						
Advertising	152,983					152,983
Subscriptions	14,678					14,678
Annual scientific meeting:						
Course revenue	63,242					63,242
Exhibit sales	47,300					47,300
Computer and production services	76,291					76,291
Conferences	81,536					81,536
Dues collection fees	24,083					24,083
Gain on sale of investments		261,747	62,020	5,244		329,011
Grant revenue	256,508					256,508
Administrative service revenue	40,000					40,000
Rental income	286,109	6,603				292,712
Other	102,854	21,500				124,354
	$3,669,922	$346,535	$ 97,753	$10,634	$67,783	$4,192,627
EXPENSES:						
Office of the Director	$ 688,648					$ 688,648
Administration and physician education	456,691	$ 6,196	$ 34,926	$ 5,000		502,813
Communications and professional relations	608,198					608,198
Finance, hospital-physician relations, and special projects	498,075					498,075
Government relations and membership development	628,732					628,732
General, membership, operations, and meeting planning	954,034	19,296				973,330
Valuation allowance for marketable securities		80,122				80,122
	$3,834,378	$105,614	$ 34,926	$ 5,000	$ —0—	$3,979,918
REVENUES OVER (UNDER) EXPENSES BEFORE NET INCOME OF UNCONSOLIDATED SUBSIDIARIES	$ (164,456)	$240,921	$ 62,827	$ 5,634	$67,783	$ 212,709
NET INCOME OF UNCONSOLIDATED SUBSIDIARIES			119,328			119,328
REVENUES OVER (UNDER) EXPENSES	$ (164,456)	$240,921	$182,155	$ 5,634	$67,783	$ 332,037

AUDITOR'S REPORT

On January 22, 1988, Touche Ross & Co., a Lansing-based certified public accounting firm, examined the balance sheet of Michigan State Medical Society as of November 30, 1987, and the related statements of revenues and expenses, changes in fund balances, and changes in financial position for the year then ended.

In the opinion of Touche Ross & Co., the balance sheet on page 10 and the statement of revenues and expenses listed above "present fairly the financial position of the Michigan State Medical Society at November 30, 1987, and the results of its operations and changes in its financial position for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year."

WHOM TO CALL AT MSMS HEADQUARTERS

Executive Director: William E. Madigan
Assistant Director: Kevin A. Kelly

Address changes	*Peg Berry*
Advertising (in Michigan Medicine*)*	*Betty McNerney*
AMA Delegation	*Sherry Wellman*
Annual Scientific Meeting Program	*Sherry Fent*
Arbitration	*Mary Anne Ford*
Auto Lease Plan	*Richard Campau*
Blue Cross Blue Shield/Third Party Payors	*Thomas White*
Board of Medicine	*Dan Farhat*
Continuing Medical Education	
Accreditation	*Katie Brewbaker*
Category I Calendar (in Michigan Medicine*)*	*Sherry Fent*
MSMS-Sponsored Conferences	*Sherry Fent*
Dues Billing & Payments	*Peg Berry*
Financial Operations	*Richard Campau*
Graduate Medical Education	*Sherry Fent*
Group Health Insurance Plan	*Barb Zimmerman*
Health Education Foundation	*Vada Davis*
HMOs/PPOs	*Thomas White*
Hospital Medical Staff Relations	*Tom Plasman*
Impaired Physicians Program	*Katie Brewbaker*
Judicial Commission	*Katie Brewbaker*
Legislation	*Terry Vanderveen*
Loss Prevention Risk Management	*Dan Farhat*
Maternal Health Conference	*Sherry Fent*
Media Relations	*David Fox*
Medicaid	*Mary Anne Ford*
Medical Assistants	*Caroline Kimmel*
Medical Ethics	*Katie Brewbaker*
Medicare	*Tom White*
Medigram	*Judy Marr*
Member Benefits (including insurance programs)	*Richard Campau*
Membership Records	*Peg Berry*
Membership Recruitment	*Deborah Zannoth*
Michigan Allergy Society	*Viola Heins*
Michigan Association for Medical Education	*Viola Heins*
Michigan Doctors Political Action Committee	*Kevin Kelly, Dan Farhat*
Michigan Chapter, American College of Surgeons	*Viola Heins*
Michigan Medicine *(MSMS Journal)*	*Judy Marr, Betty McNerney*
Michigan Society of Anesthesiologists	*Caroline Kimmel*
Michigan Society of Internal Medicine	*Caroline Kimmel*
Michigan Society of General Surgeons	*Caroline Kimmel*
Michigan Society of Pathologists	*Viola Heins*
Michigan Society for Respiratory Therapy	*Caroline Kimmel*
MSMS Auxiliary	*Viola Heins*
MSMS Committee Meeting Schedule	*Katie Brewbaker*
MSMS House of Delegates	*Richard Campau*
MSMS Meeting Facilities	*Linda Munson*
MSMS Travel Programs	*Donna Farougi*
Peer Review Organization of Michigan (PROM)	*John Richards*
Physician Legislative Network	*Dan Farhat*
Physician Service Group, Inc.	*John Richards*
Practice Management	*John Richards*
Professional Liability Insurance	*Richard Campau*
Public Health Liaison	*Mary Anne Ford*
Public Relations	*Sherry Wellman*
Specialty Societies	*Donna Farougi*

MICHIGAN STATE MEDICAL SOCIETY
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GREAT RATES & GREAT DEALS
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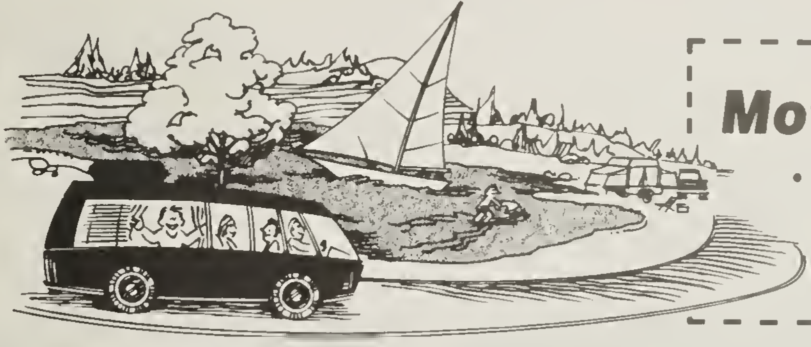


Motor Homes

- 8.9% Annual Percentage Rate - Adjustable
- Repayment terms up to 84 months
- Offer available for new motor homes financed through June 30, 1988

Boats

- 10.75% Annual Percentage Rate - Fixed rate with up to 60 months to repay for loans up to $20,000
- 8.9% Annual Percentage Rate - Adjustable rate with up to 72 months to repay for loans up to $20,000
- 8.9% Annual Percentage Rate - Adjustable rate with up to 10 years to repay for loans of $20,000 or more
- Offers available for new boat loans financed through May 31, 1988

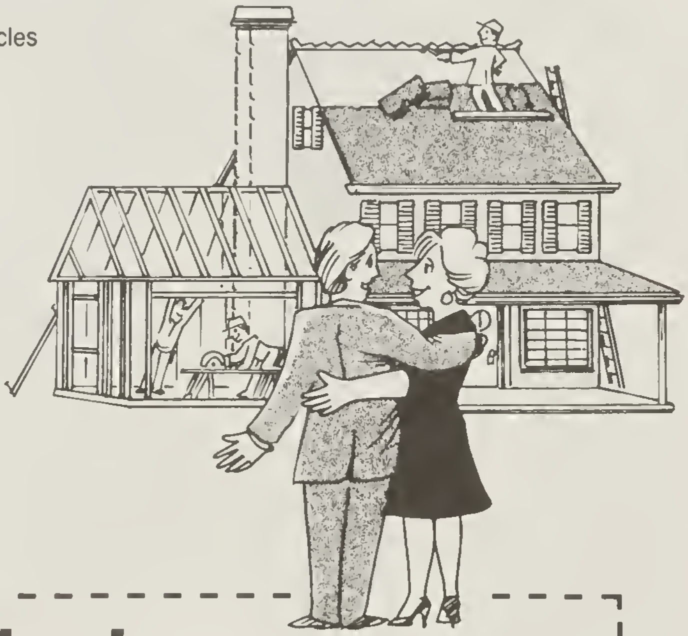
Recreation Vehicles

- 12% Annual Percentage Rate - Fixed
- Repayment terms up to 36 months
- Offer available for new recreation vehicles financed through June 30, 1988

Additional rates and terms are available for motor homes, recreation vehicles and boats. Just contact the credit union loan department for details.

Home Improvement Loans

- 9% Annual Percentage Rate with up to 12 months to repay
- 10% Annual Percentage Rate with up to 24 months to repay
- 11% Annual Percentage Rate with up to 36 months to repay
- Minimum loan of $1,000 required to receive the above rates
- Maximum loan of $50,000
- Offers available through May 31, 1988



Vacation Loans

- Closed-end loan with maximum repayment term up to 24 months
- 11.75% Annual Percentage Rate - Fixed
- Minimum $1,500 loan to receive the above rate
- Provide receipt of travel tickets or rent-a-car and receive $50.00 (only available if you receive a credit union vacation loan)
- Offer available through June 30, 1988

If you're a credit union member or eligible for membership, call 1-800-327-3167 or stop by the credit union office today. Be sure to present these coupons to receive your great rates and deals. Plus, watch for future coupons for other great deals throughout the year.

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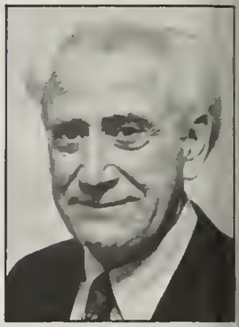
Walker

Joseph Rogers, MD, Grosse Ile, and **Anton Westveld, MD**, Mount Clemens, have been named medical directors of the Detroit Heart Institute, which is housed at Detroit Osteopathic Hospital.... **William W. O'Neill, MD**, Ann Arbor, has been appointed director of the Division of Cardiovascular Diseases at William Beaumont Hospital. ...**Robert F. Kowalski, MD**, Troy, a Beaumont Emergency Center physician, recently was certified as a diplomat by the American Board of Emergency Medicine. The Board requires that the physician be recertified every 10 years.... **Robert L. Tupper, MD**, Grand Rapids, associate professor of medicine and director of medical education at Blodgett Memorial Medical Center, wrote an article titled "What the Debate on Resident Hours Really Means" in the November issue of *Hospital Physician Magazine*.... **Howard Brody, MD, PhD**, East Lansing, coordinator of the Medical Humanities Program at Michigan State University, has written a book titled *Stories of Sickness*, published by the Yale University Press.... **Ching-Chung Chou, MD, PhD**, East Lansing, professor of physiology and medicine at Michigan State University, recently spent 14 weeks as a Fulbright Scholar in Brazil. He presented an eight week course on "Advanced Physiology of the Digestive System" to graduate students, faculty members and hospital personnel at the University of Pernambuco in Recife.... **Shirley Siew, MD**, East Lansing, professor of pathology at Michigan State University, presented a paper titled "Ultrastructure of Human Atrial Myxoma" at the Great Lakes Electron Microscopy Association meeting in Toledo, Ohio.... **Clarence S. Livingood, MD**, Grosse Pointe, chairman emeritus and founder of the Department of Dermatology at Henry Ford Hospital, recently received a Presidential Citation from the American Academy of Dermatology.... **Sheldon Kantor, MD**, Southfield, has been elected chief of staff, Sinai Hospital, Detroit.... **Eldred G. Zobl, MD**, Bloomfield Hills, whose practice is in cardiology, has been elected president of Providence Hospital's medical staff.... **James S. McGeehan, MD**, Owosso, has been honored for 30 years of local medical service by the Memorial Hospital-Owosso. ...**Maurice Castle, MD**, Detroit, and his wife, Helen Castle, February 20 received the Friends of Mercy award for their services, from Mount Carmel Mercy Hospital and the Samaritan Health Center.... **Robert H. Burke, MD, DDS, MS**, was elected vice-president at the annual meeting of the American College of Oral and Maxillofacial Surgery. Doctor Burke also chairs the National Committee for the Standardization of Orthognathic Surgery. ...**Attila Ulgenalp, MD**, Pontiac, recently was elected chief of staff at St. Joseph Mercy Hospital. His two-year term began on January 1, 1988.... **Raymond W. Ruddon, MD**, Ann Arbor, professor and chairman of the Department of Pharmacology at the University of Michigan Medical School, has been named the Sterling-Sullivan Visiting Professor in Pharmacology at the Morehouse School of Medicine in Atlanta, Georgia.... **James Walker, MD**, Flint, was elected recently to the St. Joseph Hospital Board of Trustees.... **Peter D.**

Continued on page 228

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PHYSICIANS
IN THE NEWS/Continued

Van Vliet, MD, Grand Rapids, was elected president of the Kent Medical Foundation at its annual meeting on February 17, 1988. . . . **Michael Harbut, MD**, Detroit, was invited recently to Poland to help implement a program for protecting the health of Polish workers. Doctor Harbut, who represented a committee set up by congress, helped implement goals during his visit. . . . **William W. O'Neill, MD**, Ann Arbor, has been appointed director of the Division of Cardiovascular Diseases at William Beaumont Hospital. . . . **Noel VonGlahn, MD**, Northville, has been named chief of staff at St. Mary Hospital in Livonia. He previously served as secretary/treasurer of the St. Mary Hospital medical staff, and chairman of the Continuing Medical Education Committee. . . . **James Grost, MD**, St. Johns, has been named Blue Care Network-Health Central's new medical director. Doctor Grost is a lifelong resident of Lansing and St. Johns and earned his undergraduate degree at Michigan State University. He succeeds **Bonta Hiscoe, MD**, Lansing, Health Central Medical Director since 1979. ☐

VonGlahn

Grost

GAGLIARDI/Continued

vice on the program before us. We heard you and intend to follow your instructions.

Your support is paramount. Please give those you have chosen, and will choose to follow me, your trust, to practice the art of negotiation with the interest of the public and our profession always uppermost.

If I have helped to advance the respect with which this Society is perceived, I am happy. If the public is better served because of some action on our part, I am grateful. To the many physicians who have communicated their news directly to me, I am indebted.

In many ways, these have been most satisfying years, and for that I thank you. ☐

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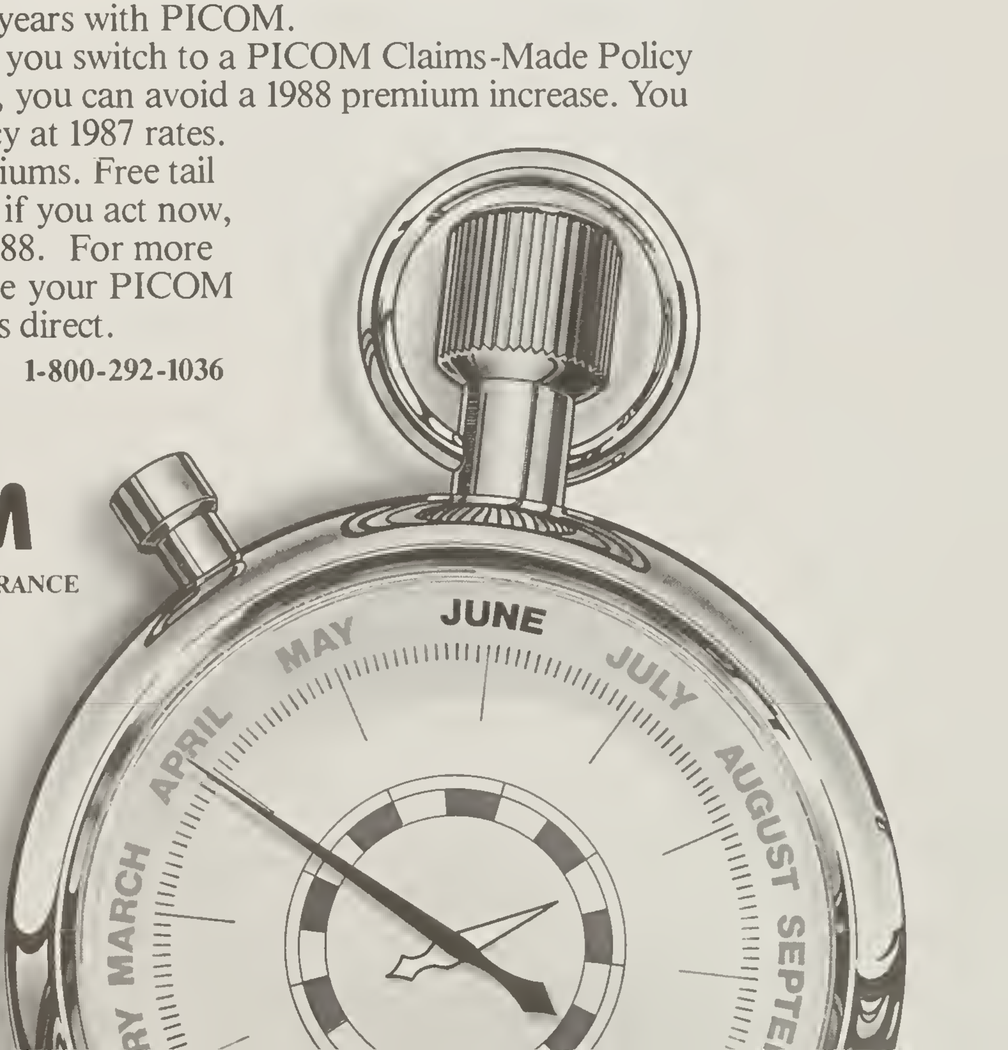

DEATHS/Continued

a 1943 graduate of Wayne State University Medical School. Doctor Husband was a general surgeon for 45 years at Mt. Carmel Hospital, where he was formerly chief of staff. He was a fellow of the American College of Surgeons, a member of the American Board of Surgery, the American Medical Association and the Wayne County Medical Society. He was a World War II Bronze Star winner as a US Navy medical corpsman.

David A. Penner, MD
Birmingham

Doctor Penner, a Detroit thoracic surgeon, died February 13 at the age of 59. He was on staff for 24 years at William Beaumont, Sinai and Harper-Grace hospitals in Detroit. He earned his bachelor's and medical degrees from Wayne State University. After residencies at Detroit Receiving and University of Michigan hospitals, he set up a private practice in Detroit. He was a certified fellow of the American College of Surgeons, a former president of the Wayne State Medical School Alumni Association and belonged to the Wayne County Medical Society, Southeastern Michigan Thoracic Association and the Detroit Surgical Society.

John Webster, MD
Armada

Doctor Webster died January 22 at the age of 78. After gradu-

Continued on page 238

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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company **2.** Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride. Bioavailability and safety *Pharmacotherapy* 1980,4(6):392-397 **3.** Skoutakis VA, Carter CA, Acchiardo SR Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics *Drug Intell Clin Pharm* 1987;21 436-440.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1 For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis

2 For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions. patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy; and certain diarrheal states

3 The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest Hyperkalemia may complicate any of the following conditions chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e g , spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium

WARNINGS

Hyperkalemia (See OVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally Potentially fatal hyperkalemia can develop rapidly and be asymptomatic

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g , spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs

Metabolic Acidosis

Hypokalemia in patients with metabolic *acidosis* should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per* se can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets

To take this medicine only as directed This is especially important if the patient is also taking both diuretics and digitalis preparations

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed

Laboratory Tests

Regular serum potassium determinations are recommended In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity Slow-K should be given to a pregnant woman only if clearly needed

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L It is not known if Slow-K has an effect on this content Caution should be exercised when Slow-K is administered to a nursing woman

Pediatric Use

Safety and effectiveness in children have not been established

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE) There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8 0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked

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Advantages of the program are that patients find it easier to pay for services, and thus are more likely to seek needed care. VISA estimates 40 percent of credit card purchases are paid off the same month they are made. Ac-

Continued on page 236

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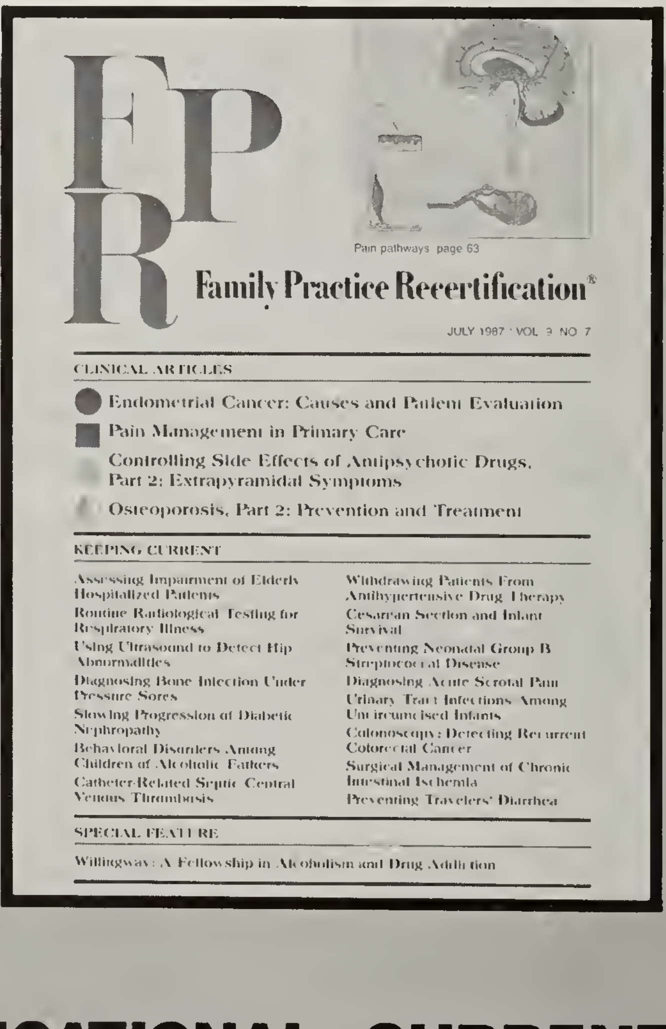

FPR

Pain pathways page 63

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- Endometrial Cancer: Causes and Patient Evaluation
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- Osteoporosis, Part 2: Prevention and Treatment

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PROGRAM/Continued

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VOL 5 NO 1 • JANUARY 1988

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Electrophysiological Testing and Nonsustained Ventricular Tachycardia / PETER R KOWEY, MD, et al

Residual Coronary Artery Stenosis after Thrombolytic Therapy · LOWELL F SATLER, MD, et al.

Assessment of Aortic Regurgitation by Doppler Ultrasound / PAUL A GRAYBURN, MD et al.

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Cardiovascular Reserve in Idiopathic Dilated Cardiomyopathy / RICKY D LATHAM, MD, et al

Overview • Coronary Angioplasty: Evolving Applications GEORGE W VETROVEC, MD

*Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.

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DEATHS/Continued

ating from the University of Michigan in 1930 with a degree in pharmacy, Doctor Webster earned a bachelor's degree, then a medical degree at Wayne State University. He practiced at Grace and Detroit Receiving hospitals. He was past president of the College of Medicine Alumni Association and was a former member of the Wayne State University Alumni Association board of directors. During World War II, he served in the Army Medical Corps as a major with the 36th General Hospital in the European Theater. He received the Legion of Merit for distinguished service.

Stewart C. Wheeler, MD
Detroit

Doctor Wheeler died February 20 at the age of 81. Doctor Wheeler, who started his general practice in 1933, was on the staff at Mt. Carmel Mercy Hospital. Born in Cheboygan, he moved to Detroit as a teenager and attended Wayne State University and Michigan State University. Doctor Wheeler was an Army Air Corps flight surgeon in the Pacific during World War II.

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East Lansing, Michigan 48826-0950
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

April

14-15, Annual Postgraduate Course in Obstetrics and Gynecology: Challenges and Changes of the 1980s. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Obstetrics and Gynecology. Contact: Betty Phillips, Office of Continuing Medical Education, The Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 15 hours Category 1 Credit.

14-15, Pediatric and Adolescent Medicine for Primary Care Physicians. Location: Henry Ford Hospital, Room 2055, Education and Research Center, Detroit. Sponsor: Henry Ford Hospital, Department of Pediatrics, Detroit. Contact: Kathy Meyers, Henry Ford Hospital, Continuing Medical Education Office, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. Approved for: 15 hours Category I Credit.

15, Michigan Allergy Society Spring Scientific Meeting: Immunologic Lung Disease. Location: Amway Grand Plaza Hotel, Grand Rapids. Sponsor: Michigan Allergy Society and Michigan State Medical Society. Contact: Viola M. Heins, Michigan Allergy Society, P.O. Box 950, East Lansing, MI 48826-0950 (517)337-1351. Approved for: 3 hours Category 1 Credit.

16, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw. Sponsor: Michigan Chapter of the American College of Emergency Physicians. Contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500. Approved for: 5 hours Category I Credit.

18-20, Ultrasound in Obstetrics and Gynecology. Location: The Towsley Center for Continuing Medical Education, The University of Michigan Medical School. Sponsor: The University of Michigan Medical School, Department of Radiology. Contact: Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 22 hours Category 1 Credit.

19, Is There a Difference Between the Practice of Medicine and the Practice of Osteopathy? Location: Clarion Conference Center, 6810 S. Cedar Street, Lansing. Sponsor: Ingham County Medical Society and MSMS Committee for Continuing Medical Education. Contact: Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)334-2320. Approved for: 6 hours Category 1 Credit.

20, Sleep Throughout the Life Cycle. Location: Fetzer Center at Western Michigan University, Kalamazoo. Sponsor: Borgess Pulmonary Services. Contact: Judy Smith, Pulmonary Services, Borgess Medical Center, Kalamazoo (616)383-4875. Approved for: 6 hours Category 1 Credit.

20, Stress in the Heart Brain Connection. Location: Amway Grand Plaza Hotel, Grand Rapids. Sponsor: Blodgett Medical Center with Grand Valley Internal Specialists, P.C. Contact: Raquelle Taylor, Blodgett Medical Center, 1840 Wealthy, S.E., Grand Rapids 49506 (616)774-7436. Approved for: 4 hours Category 1 Credit.

21-23, Michigan Association of Osteopathic Physicians and Surgeons, Inc. 89th Annual Post-Graduate Conference and Scientific Seminar. Location: Hyatt Regency Dearborn at Fairlane Town Center. Sponsor: Michigan Association of Osteopathic Physicians and Surgeons, Inc. Contact: Cathi A. Liebziet, Michigan Osteopathic Journal, 33100 Freedom Road, Farmington 48024 (313)476-2800. Approved for: 29 hours Category 1-A Credit.

23, Rheumatology Update 1988. Location: Macomb Hospital Center Auditorium, 11800 East Twelve Mile Road, Warren. Sponsor: Detroit-Macomb Hospital Corporation. Contact: Mary Beth Day, Department of Medical Affairs, Detroit-Macomb Hospital Corporation, 7815 East Jefferson Avenue, Detroit 48214 (313)499-4917. Approved for: 6 hours Category 1 Credit.

28-29, The Phlebotomy Team: Technical and Management Perspectives. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Pathology. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 201, Ann Arbor 48109-0201 (313)763-1400. Approved for: 11 hours Category I Credit.

May

2-3, Interventional Cardiology Symposium for Nurses. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Internal Medicine. Contact: Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 201, Ann Arbor 48109-0201 (313)763-1400. Approved for: 12 hours Category I Credit.

4, Geriatrics—1988. Location:Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. Sponsor: Southwestern Michigan Area Health Education Center, 4th Floor Stryker, 1521 Gull Road, Kalamazoo. Contact: Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 4th Floor Stryker Center, 1521 Gull Road, Kalamazoo 49001 (616)341-6360. Approved for: 6 hours Category 1 Credit.

4-6, Computed Tomography and Magnetic Resonance Imaging and Radiologic Technologist Program. Location: The Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Radiology. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 22.5 hours Category 1 Credit.

5-6, Annual Resident Surgeons Day and Michigan Chapter American College of Surgeons Program. Location: Novi Hilton, Novi. Sponsor: Michigan Chapter, American College of Surgeons. Contact: Viola M. Heins, Michigan Chapter, American College of Surgeons, P.O. Box 950, East Lansing 48826-0950 (517)337-1351.

5-7, Medicolegal Investigation of Death.

Continued on next page

CATEGORY I COURSES/Continued

Location: Hotel Pontchartrain, Two Washington Blvd., Detroit. Sponsor: Wayne State University School of Medicine, Department of Pathology, and Wayne County Medical Examiner's Office, with the cooperation of the Criminal Defense Attorneys of Michigan. Contact: Wayne State University School of Medicine, Division of Continuing Medical Education, 4-H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180. Approved for: 15.5 hours Category I Credit.

5-7, National Conference on Health Care Leadership and Management. Location: Sheraton Harbor Island, San Diego, CA. Sponsor: The American Academy of Medical Directors. Contact: Sherry Mason, AAMD, 4830 W. Kennedy Blvd, Suite 648, Tampa, FL 33609-2517 (813)287-2000. Approved for: 16 hours Category I Credit.

6, Seminar in Computed Tomography and Magnetic Resonance Imaging. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Radiology. Contact: Betty Phillips, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 22 hours Category I Credit.

8-13, Fourth International Symposium: Clinical Disorders of Bone and Mineral Metabolism. Location: Henry Ford Hospital Bone and Joint Specialty Center. Sponsor: Henry Ford Hospital Bone and Joint Specialty Center. Contact: Glenn A. Moore, Coordinator, Continuing Medical Education, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202 (313)876-3072. Approved for: 40 hours of Category I Credit.

9-13, 16th Annual Spring Update: Advances in Internal Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Internal Medicine. Contact: Gayle Fox, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 34 hours Category I Credit.

13, 10th Annual American College of Physicians-Michigan Chapter Associates" Meeting. Location: University of Michigan Campus, Michigan League, 922 North University, Ann Arbor. Sponsor: American College of Physicians, Michigan Chapter. Contact: Dennis Schaberg, MD, Taubman Center 3116/0378, 1500 East Medical Center Drive, Ann Arbor 48109 (313)936-4386. Approved for: 5 hours Category 1 Credit.

16-17, Recent Trends in the Electrophysiologic Assessment of Auditory Function: Neuro-Otologic and Intraoperative Applications; Pediatric and Neonatal Applications. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Otolaryngology. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 14 hours Category I Credit.

19, MSMS Sports Medicine Conference. Location: Hilton Inn, 7501 Saginaw, Lansing. Sponsor: Michigan State Medical Society. Contact: Sherry L. Fent, Chief, Physician Education, Michigan State Medical Society, P.O. Box 950, East Lansing, 48826-0950 (517) 337-1351. Approved for: 5 hours Category I Credit.

19-20, Clinical Ischemic Syndromes: Mechanisms and Consequences of Tissue Injury. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Surgery and the Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education. Contact: Debbie DeSmyther, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor, 48109 (313)763-1400. Approved for: 14 hours Category I Credit.

20-21, Current Concepts in Glaucoma: 60th Annual Ophthalmology Spring Conference in conjunction with the 10th Annual Midwest Glaucoma Symposium. Location: W. K. Kellogg Eye Center, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Ophthalmology. Contact: Arlene Bradford, Towsley Center for Continuing Medical Education, University of Michigan, Ann Arbor 48910 (313)763-1400. Approved for: 13 hours Category I Credit.

25, Client Services through Clinical Excellence. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. Sponsor: Southwestern Michigan Area Health Education Center, 4th Floor Stryker, 1521 Gull Road, Kalamazoo. Contact: Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 1521 Gull Road, 4th Floor Stryker, Kalamazoo 49001 (616)341-6360. Approved for: 6 hours Category I Credit.

June

2-3, Current Topics in Blood Banking: 15th Annual Symposium. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Pathology. Contact: Gayle Fox, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 12 hours Category I Credit.

2-3, 14th Annual Kalamazoo Symposium for Michigan Neonatologists and Neonatal/Perinatal Medicine Fellows. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. Sponsor: Neonatology Service of the Pediatric Section—Bronson Mead Johnson Laboratories. Contact: John Hartline, MD, Neonatology Service of the Pediatric Section, Bronson Methodist Hospital, 252 East Lovell Street, Kalamazoo 49007 (616)341-6469. Approved for: 7.25 hours Category I Credit.

3, Seventh Annual Cleft Palate Symposium. Location: Waterfront Inn, Traverse City. Sponsor: Michigan Cleft Palate Association, Center for Human Services, Western Michigan University. Contact: Janet Wilson, Center for Human Services, Western Michigan University, Kalamazoo 49008 (616)383-4941. Approved for: 5 hours Category 1 Credit.

9, The 6th Annual Clinical Laboratory Computer Symposium. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Pathology. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, The Univesity of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 15 hours Category I Credit.

21, Preventive Oncology. Location: Clarion Conference Center, 6810 S. Cedar Street, Lansing. Sponsor: Ingham County Medical Society and MSMS Committee for Continuing Medical Education. Contact: Samuel M.

McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)332-2320. Approved for: 6 hours Category I Credit.

July

8-11, Fourteenth Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. Sponsor: University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. Contact: Betty Phillips, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 11 hours Category I Credit.

21-24, Fifteenth Michigan Emergency Medicine Assembly: EMS Concepts 88 and Base Station Symposium. Location: Hilton Shanty Creek, Bellaire. Sponsor: Michigan Chapter of the American College of Emergency Physicians. Contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. Approved for: 22 hours Category I Credit.

21-24, Occular Surgery Update: Newest Techniques, Complications and Management of Ocular Tumors. Location: Grand Hotel, Mackinac Island. Sponsor: Michigan Ophthalmological Society. Contact: Christine Jourdain, 412 Eastland Professional Bldg., Harper Woods 48225 (313)839-0311. Approved for: 8 hours Category I Credit.

24-27, 2nd Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Hotel, Mackinac Island. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)7631400. Approved for: 13 hours Category I Credit.

25, 42nd Annual Scientific Assembly. Location: Grand Traverse Resort, Acme. Sponsor: Michigan Academy of Family Physicians. Contact: Julie L. Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151. Approved for: 25.5 hours Category I Credit.

28-29, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Grand Traverse Village. Sponsor: Munson Medical Center. Contact: Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City 486842386 (616)922-9546. Approved for: 13 hours Category I Credit.

August

7-10, Internal Medicine Update. Location: Grand Hotel, Mackinac Island. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School 48109-0201 (313) 763-1400. Approved for: 11 hours Category I Credit.

13-14, Endocrinology and Diabetes Update. Location: Grand Traverse Resort Village, Grand Traverse Village. Sponsor: University of Michigan Medical School, Division of Endocrinology and Metabolism, Department of Internal Medicine. Contact: Karen Brown, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 7 hours Category I Credit.

20-22, Cardiology Update. Location: Grand Hotel, Mackinac Island. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 10 hours Category I Credit.

September

15-16, Neonatal Emergencies. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Pediatrics and Communicable Diseases, Section of Newborn Services and Pediatric Pulmonary Medicine. Contact: Steven M. Donn, MD, Women's Hospital L3032, Box 0254, Ann Arbor 48109-0254 (313)763-4109. Approved for: 14.5 hours Category I Credit.

15-17, 11th Annual Seminar in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

19-20, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

22-24, 19th Annual International Symposim on Implant Surgery for the Hand, Upper Extremity and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. Sponsor: Michigan State University College of Human Medicine, The Intrernational Federation of Societies for Surgery of the Hand, The Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. Contact: Alfred B. Swanson, MD, Blodgett Professional Building, 1900 Wealthy, S.E., Suite 290, Grand Rapids 49506 (616)774-0440. Approved for: 18 hours Category I Credit.

October

1, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw. Sponsor: Michigan Chapter of the American College of Emergency Physicians. Contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. Approved for: 5 hours Category I Credit.

2, Michigan Chapter American Academy of Pediatrics Annual Scientific Meeting. Location: Grand Traverse Resort and Conference Center, Traverse City. Sponsor: Michigan Chapter American Academy of Pediatrics. Contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, MI 48018 (313)553-3646. Approved for: 7 hours Category I Credit.

MEETINGS

MICHIGAN STATE MEDICAL SOCIETY
1866

MSMS MEETINGS

April

29-5/1, MSMS Board of Directors and House of Delegates, Hyatt Regency, Dearborn, contact: William Madigan (517)337-1351.

May

19, MSMS Sports Medicine Conference, Hilton Inn, Lansing, contact: Sherry L. Fent (517)337-1351.

September

14, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

October

19, 1988 Public Affairs Leadership Conference, Hilton Inn, Lansing, contact: Mary Anne Ford (517)337-1351.

November

8-10, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent (517)337-1351.

16, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETINGS

April

22-23, Biotechnology Targets AIDS: A Clinical Perspective, sponsored by American Medical Association, Crystal Gateway Marriott Hotel, Arlington, VA, contact: Bill Silberg, American Medical Association, Department of Public Information, 535 North Dearborn Street, Chicago, IL 60610 (312)645-4417.

June

26-30, AMA Annual Meeting, Chicago Hilton and Towers, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4392 (312) 645-4344.

December

6-9, AMA Interim Meeting, Atlanta, GA contact: AMA, 535 North Dearborn St., Chicago 60610 (312) 645-4344.

MICHIGAN SPECIALTY SOCIETY MEETINGS

April

15, Michigan Allergy Society Spring Scientific Meeting: Immunologic Lung Disease, Amway Grand Plaza Hotel, Grand Rapids, contact: Michigan Allergy Society, Viola M. Heins, P.O. Box 950, East Lansing 48826-0950 (517)337-1351.

16, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500.

19-22, Michigan Society for Respiratory Care Annual Meeting, Amway Grand Plaza Hotel, Grand Rapids, contact: Caroline Kimmel, 1305 Abbott Road, P.O. Box 950, East Lansing, 48826-0950 (517)337-1351.

May

5-6, Annual Resident Surgeons Day and Michigan Chapter, American College of Surgeons Program, Novi Hilton, Novi, contact: Michigan Chapter, American College of Surgeons, Viola M. Heins, P.O. Box 950, East Lansing 48826-0950 (517) 337-1351.

14, Michigan Society of Internal Medicine Annual Spring Meeting, Embassy Suites Hotel, Southfield, contact: Caroline Kimmel, 1305 Abbott Road, P.O. Box 950, East Lansing 48826-0950 (517)337-1351.

21, Michigan Society of Pathologists Spring Meeting, St. Clair Inn, St. Clair, contact: Michigan Society of Pathologists, Viola M. Heins, P.O. Box 950, East Lansing 48826-0950 (517)337-1351.

June

2-3, Michigan Occupational Medicine Association Annual Meeting, Shanty Creek, contact: Richard Rood, MD, Chrysler Corporation,

Continued on page 244

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MEETINGS/Continued

29232 Gloede, Warren 48093 (313) 977-5001.

17-19, Annual Meeting—Michigan Association of Neurological Surgeons, Grand Traverse Resort, Traverse City, contact: William F. Chandler, MD, 1500 E. Medical Center Drive, Ann Arbor 48109 (313)936-5020.

July

21, Fifteenth Michigan Emergency Medicine Assembly—EMS Concepts 88 and Base Station Symposium, Michigan Chapter of the American College of Emergency Physicians, Hilton Shanty Creek, Bellaire, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500.

25, 42nd Annual Scientific Assembly, Michigan Academy of Family Physicians, Grand Traverse Resort, Acme, contact: Julie L. Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151.

August

19-20, Michigan Society of Thoracic Surgeons Annual Scientific Meeting, Grand Hotel, Mackinac Island, contact: Luis A. Tomatis, MD, President, 21 Michigan Street, N.E., Suite 550, Grand Rapids 49503 (616)459-6577.

October

2, Michigan Chapter, American Academy of Pediatrics Annual Scientific Meeting, Grand Traverse Resort and Conference Center, Traverse City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018 (313)553-3646.

9, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500.

NATIONAL SPECIALTY SOCIETIES

April

14-17, American College of Preventive Medicine Annual Scientific Meeting, Westin Peachtree Plaza, Atlanta, GA, contact: American College of Preventive Medicine, 1015 15th Street, N.W., Suite 403, Washington, DC 20005 (202)789-0003.

17-23, American Academy of Neurology Annual Meeting, Convention Center, Cincinnati, OH, contact: American Academy of Neurology, 2221 University Avenue, S.E., Suite 335, Minneapolis, MN 55414 (612)623-8115.

18-20, American Association for Thoracic Surgery Annual Scientific Meeting, Century Plaza, Los Angeles, CA, contact: American Association for Thoracic Surgery, 13 Elm Street, Manchester, MA 01944 (617) 927-8330.

23-29, American Occupational Medical Association Annual Meeting, New Orleans Marriott, New Orleans, LA, contact: American Occupational Medical Association, 2340 S. Arlington Heights Road, Suite 400, Arlington Heights, IL 60005 (312)228-6850.

24-28, American Association Neurological Surgeons Annual Meeting, Toronto, Ontario, contact: American Association Neurological Surgeons, 22 S. Washington, Suite 100, Park Ridge, IL 60068 (312) 692-9500.

29-30, American Academy of Facial Plastic and Reconstructive Surgery Interim Meeting, The Breakers, Palm Beach, FL, contact: American Academy of Facial Plastic and Reconstructive Surgery, 1101 Vermont Avenue, N.W., Suite 404, Washington, DC 20005 (202)842-4500.

May

1-4, American Association of Plastic Surgeons Annual Scientific Meeting, The Breakers, Palm Beach, FL, contact: American Association of Plastic Surgeons, University of Chicago, Box 269, 5841 S. Maryand Avenue, Chicago, IL 60637 (312) 962-6302.

1-5, American College of Obstetricians and Gynecologists Annual Scientific Meeting, Boston Sheraton, Boston, MA, contact: American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SW, Suite 300 East, Washington, DC 20024 (202)638-5577.

1-6, American Association of Pathologists Annual Scientific Meeting, Las Vegas, NV, contact: American Association of Pathologists, 9650 Rockville Pike, Bethesda, MD 20814 (301)530-7130.

2-4, Consensus Development Conference on Cochlear Implants, National Institute of Health, Bethesda, Maryland, contact: Michael J. Bernstein, Office of Medical Applications of Research, National Institutes of Health, Bethesda, Maryland 20892 (301)496-1143.

7-13, American Psychiatric Association Annual Scientific Meeting, Le Sheraton Centre, Montreal, Canada, contact: American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005 (202)682-6000.

19-22, American Geriatrics Society Annual Meeting, Disneyland Hotel, Anaheim, CA, contact: American Geriatrics Society, 770 Lexington Avenue, Suite 400, New York, NY 10021 (212)688-2150.

June

3-7, American Association of Clinical Urologists Annual Meeting, Sheraton/Marriott, Boston, MA, contact: American Association of Clinical Urologists, 21510 S. Main Street, Carson, CA 90745 (213)549-3470.

9-12, 17th Annual Scientific Assembly, American College of Emergency Physicians, Mission Hills Resort Hotel, Rancho Mirage, CA, contact: CAL/ACEP, 505 N. Supulveda Blvd., –12-14, Manhattan Beach, CA 90266 (213)374-4039.

20-23, American Orthopaedic Association Annual Scientific Meeting, The Homestead, Hot Springs, VA, contact: American Orthopaedic Association, 222 S. Prospect Avenue, Park Ridge, IL 60068 (312)823-7186.

September

14-17, American Group Practice Association Annual Meeting, Hotel Intercontinental, San Diego, CA, contact: American Group Practice Association, 1422 Duke Street, Alexandria, VA 22314 (703)838-0033.

23-24, American Academy of Facial Plastic and Reconstructive Surgery Annual Meeting, Washington, DC, contact: American Academy of Facial Plastic and Reconstructive Surgery, 1101 Vermont Avenue, N.W., Suite 404, Washington, DC 20005 (202)842-4500.

26-29, American College of Emergency Physicians Scientific Meeting, New Orleans Convention Center, New Orleans, LA, contact: American College of Emergency Physicians, P.O. Box 619911, Dallas, TX 75261-9911 (214)550-0911.

October

1-6, American Academy of Family Physicians Annual and Scientific Meetings, New Orleans Marriott, New Orleans, LA, contact: American Academy of Family Physicians, 1740 W 92nd Street, Kansas City, MO 64114 (816)333-9700.

3-7, American College of Chest Physicians Scientific Meeting, Anaheim Hilton, Anaheim, CA, contact: American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068 (312)698-2200.

8-12, American Academy of Ophthalmology Annual Scientific Meeting, Las Vegas, NV, contact: American Academy of Ophthalmology, P.O. Box 7424, 655 Beach, San Francisco, CA 94120 (415)561-8500.

8-12, American Society of Anesthesiologists Annual Meeting, San Francisco Hilton, San Francisco, CA, contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068 (312) 825-5586.

17-19, American College of Gastroenterology Annual Meeting, Hilton, New York, NY, contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944 (617)927-8330.

OTHER MEETINGS

April

13, New Future for the Blues, Oakland County Medical Society, contact: Mary Sue Meyer, Executive Director, 346 Park Street, Birmingham 48009 (517)790-2665.

25-26, Twelfth Annual Conference of the Michigan Association for Infant Mental Health, Ann Arbor, contact: Thomas Horner, PhD, Child and Adolescent Psychiatric Hospital, University of Michigan Medical Center, Ann Arbor 48109 (313)764-5304.

May

18-20, Michigan Life Savers '88, The Michigan Office of Highway Safety Planning, contact: Office of Highway Safety Planning, 300 S. Washington Square, Suite 300, Lansing 48913 (517)334-7900.

June

4, AIDS: A First Responder's Approach, sponsored by University of Michigan Medical School, Section of Emergency Services, East Central AIDS Education and Training Center, contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400.

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THANKS TO OUR ADVERTISERS

Advance Medical & Research	227
AMA	193, 198
American Cancer Society	196, 200
Ayerst	201-204
Bennethum Computers	210
Brown Pharmaceutical	209
Campbell Labs	205
Cardiology Board Review	236
Ciba-Geigy	188-190, 231-232
Comerica	235
Current Concepts Seminars	196
Detroit-Macomb Hospital Corp.	200
Eli Lilly	197
Family Practice Recert	234
Group Health Inc.	210
Hospital & Health Services Credit Union	225
Lab of Clinical Medicine	206
M-Labs	233
Manufacturers Bank	195
Medical Billing Service	237
MDPAC	199
MI Dept. of Corrections	208
MI Health Billing & Collection Serv.	207
MPMLC	211
Palisades Pharmaceutical	212
Physician Placement Service	233
Physician Service Group (PSG)	IFC
PICOM	229
Roche	IBC, BC
Stratton-Cheeseman	243
Trans Global Tours	238
U.S. Air Force	230
Wayne State Alumni	228

Most Satisfying Years

By Carl A. Gagliardi, MD

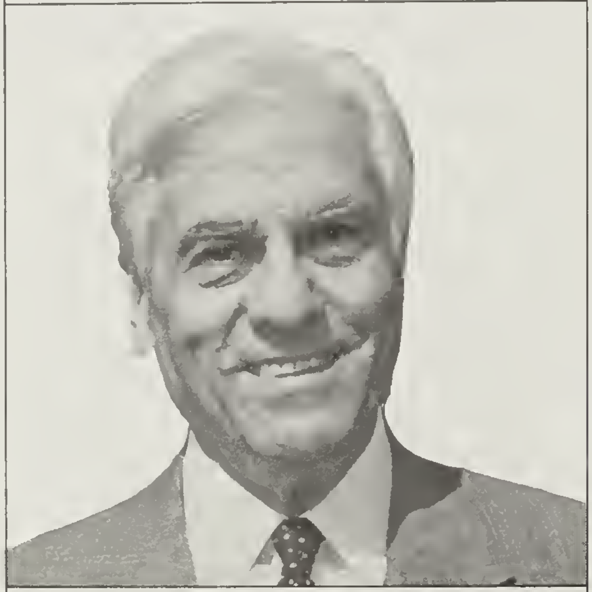
With mixed emotions I sit down today to write my final President's Page. It will not be easy. I have tried to write this several times, only to push the pad and pen away and postpone the inevitable.

How could I have known 19 years ago what faced me when I reluctantly agreed to be the candidate to represent the southwest district to the Wayne County Medical Society Council? That little "Yes" has played a vital part in my life.

Actually, I have been a member of the Wayne County, Michigan State and American Medical associations for three and one-half decades, only a little less time than I have been married to a wonderful lady, a great wife, mother, and physician — Doctor Marjory Stewart Gagliardi. Without her support I would have been a lesser person. I ran to her to gloat about my presumed successes and to seek solace for my moments of despair. She was up to the task.

These years have had wonderful, exhilarating days, but there have been days filled with depression as well. It is of these types of feelings that I wish to write. I have served you long enough and I am now old enough that I take the prerogative to address the extremes forthrightly.

I have always agreed that with privilege comes responsibility. When you offered me the privilege of leadership, I had to accept the responsibility to perform for you through successes and failures. It is easy for me, and probably for most of us, to serve when there is success. It is difficult when there is failure.


Carl A. Gagliard, MD

Since success is easier, let me talk about that first. In my various capacities during these years, my first obligation was to communicate and to reason with a large variety of interest groups. I promised you that I would go anywhere, at any time, and meet with anyone for the advancement of quality medical care. I believe I have done that. I have traveled from the extreme western tip of the Upper Peninsula to the southeast corner of the state, from the southwestern to the northeastern areas — actually blanketing the state. I have met with physicians, auxilians, deans, businessmen, third-party payors, news media, consumers' groups, state and national legislators, governors, and our patients — the public. I have been a participant in many debates and programs — both friendly and unfriendly — but I hope I represented you well in all circumstances. I believe we have strengthened old friendships while making new friends. We have forced some who disagreed with us to rethink their position.

October 22, 1985, Rally Day, will always be a day I remember with joy and hope. Joy because we were great and those we wished to influence took notice. Hope because when we really agree on our cause, we can sublimate our differences and act not as a few physicians crying in the wilderness but as a mighty wave capable of exerting extreme influence and power. We need to develop that more.

My failures are legion, but the one that bothers me the most is the difficulty in communicating with the membership. We can only succeed when we act in unison. That does not mean we always agree, but it should mean that we address our differences together and go forth to the public with as close a consensus as possible.

The Michigan State Medical Society has spent more of its resources in the past few years on getting the word out to its members than ever before. The leadership and staff have traveled more.

We had only the fourth special session of the House of Delegates in our 122 years to seek your ad-

Continued on page 228

Doctor Gagliardi is 1987-88 MSMS president.

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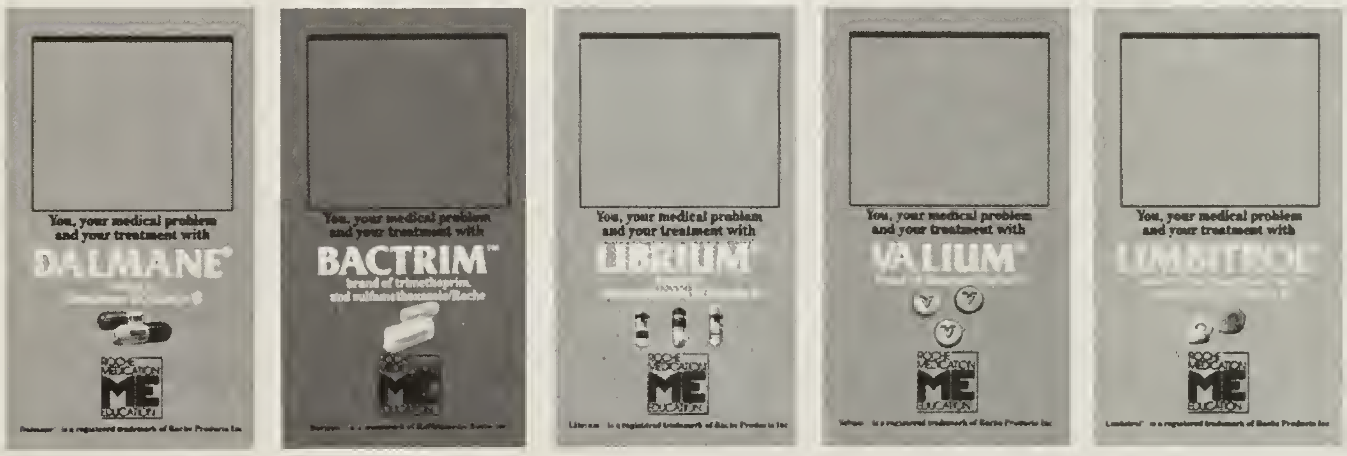
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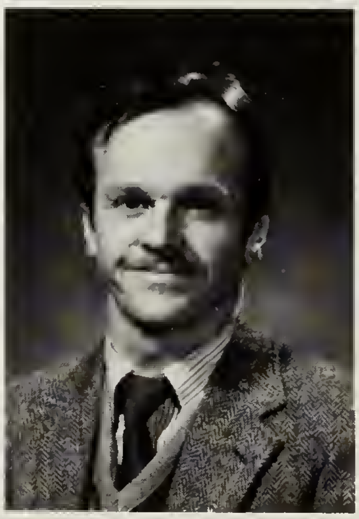

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MICHIGAN MEDICINE

MAY 1988 VOL. 87, NO. 5

Special Report

The quality of medical care delivery was once the sole concern of the individual physician. Few persons looked over the physician's shoulder or second-guessed the physician's decisions. That is no longer the case. In this month's special report, *Michigan Medicine* features a variety of articles on quality of care issues and trends, including an introductory article by Gerald H. Mandell, MD, president of the Medical Associations for Risk Management; a recap of the recent annual meeting of the MSMS Hospital Medical Staff Section where "Quality of Care" was the theme; comments by HMSS Chairman Gary D. Maynard, MD; a look at the pitfalls in medical practice, by Donald H. Kuiper, MD, past chairman of the Michigan Board of Medicine; and a commentary on quality of care by Janet K. Baum, MD, Washtenaw County Medical Society president. 252

Features

Fetal Alcohol Syndrome
Cases persist despite broad public awareness
— By Patrick Fitzgerald 262

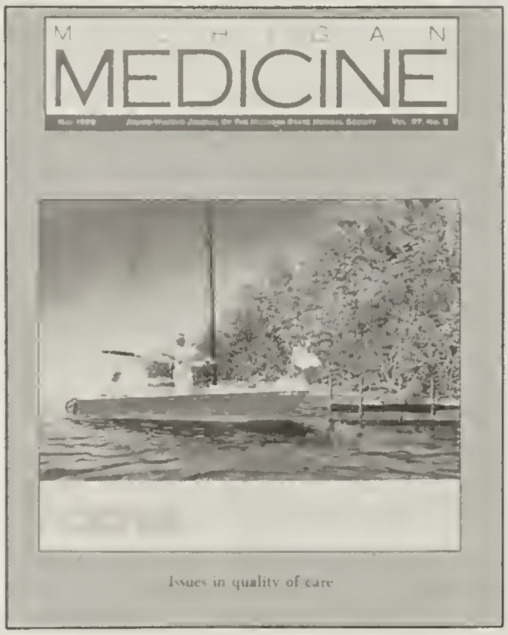
Frederick W. Bryant, MD
A profile of the new MSMS president
— By Betty J. McNerney, Managing Editor 270

The 27th Annual Michigan Conference on Maternal and Perinatal Health
A photo feature 274

School Workplace Wellness Conference
A Bridgeport, Michigan educator benefits 278

Board of Medicine actions 281

Michigan Medicine
MSMS journal wins another first place award 298



Departments

In my opinion
"Physician fees should go directly to the Board of Medicine"
By James L. Fenton, MD 250

Letters 251

Medical Newsfronts 280

Physicians in the news 290

Deaths 300

New Members 304

Category I courses 311

Meetings 313

Classified 316

Ad index 317

President's page
"A committee of one"
By Frederick W. Bryant, MD 318

In next month's issue of *Michigan Medicine:* New developments with the MSMS Physician's Recovery Network.

Cover photo developed by Gray & Kilgore Inc., a Troy marketing communications firm, for MSMS. The poster is the third in an MSMS series for member physician offices. Copies are available by contacting the MSMS Department of Communications and Professional Relations.

IN MY OPINION

Physician fees should go directly to the Board of Medicine

By James L. Fenton, MD, FACR

Adequate funding of the Michigan Board of Medicine has been a concern of the Michigan State Medical Society and the Board of Medicine members for many years. A popular misconception is that license fees paid by Michigan physicians all go directly to the Board of Medicine for its use. However, in fact, the fees go into the State of Michigan general fund, and the Board of Medicine is allocated money in the budget of the Department of Licensing and Regulation by a vote of the legislature.

Doctor Fenton

During the past 10 years, members of the Board of Medicine have been asked at intervals to forego their small per diem payment and to stop charging business telephone calls to the Board of Medicine. Board members also were asked to attend meetings of the Federation of State Medical Boards at their own expense, since no monies were budgeted. The Board of Medicine staff often was shorthanded with a very large workload, and no relief in sight.

It would seem reasonable, in view of increasing pressure by the public to police physicians, to markedly increase funding to the Michigan Board of Medicine. However, the Michigan State Medical Society would be foolish to press for a fee increase from member physicians, when only the legislature under the present law can allocate money to the Board of Medicine by way of the Department of Licensing and Regulation budget.

In my opinion the legislature should allow direct allocation of physician fees to the Board of Medicine, and should allow the Board of Medicine to set the fee schedule. MSMS should lobby vigorously to change the present policy of the legislature, and therefore to permit direct funding in order to make our Board of

Continued on page 293

Doctor Fenton is a member of the MSMS Committee on Publications.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserves the right to accept or reject advertising copy. Products and services advertised in *Michigan Medicine* are neither endorsed nor warranted by MSMS.

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"Expert" witnesses should be experts

What is our responsibility when we testify as an expert in a malpractice case? Certainly, we all have a civic duty to testify when necessary. But, if we are going to testify as experts, we should be experts. Also, the testimony should be the unadulterated, unslanted truth.

As we all know, the legal system in Michigan has used out-of-state experts, often because there have not been local physicians who would testify for the plaintiff. I have seen several cases lately of out-of-state physicians with no expertise in their fields of testimony. The new law may not allow these physicians to testify as experts.

As chairman of the Investigation and Allegations Committee and of the Board of Medicine, I've been contacted by several physicians who are concerned about the testimony of the plaintiff's experts.

Examinations of the ("experts") depositions showed testimony that was so far slanted or so far from reflecting an accurate assessment of standards of practice as to indicate serious bias. When these physicians are licensed in the state of Michigan, the Board will examine this kind of testimony for possible sanctions.

Continued on page 296

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1866

SPECIAL REPORT

Quality of care: how times have changed

By Gerald H. Mandell, MD, president
Medical Associations for Risk Management

The quality of medical care delivery has been a concern of physicians and hospitals for decades. The primary purpose of the hospital medical staff is to assure appropriate care of its patients. These efforts are codified in medical staff rules and regulations, in the credentialing process, and in compliance with Joint Commission requirements. Times have changed.

Now, patients, the government, employers, insurance companies and other private groups demand determination of whether high-quality care is delivered in a timely and appropriate fashion.

The malpractice insurance climate has focused outsiders' attention on physicians' attitudes and actions as all concerned try to reduce the numbers of suits filed and sizes of awards made.

MSMS has done much over the years to help its members respond constructively to the new attention on their performance.

- In 1987 the MSMS House of Delegates passed to the Board a resolution calling for a feasibility study of a state health plan through which patients can obtain quality, cost-effective medical care.

This was an attempt on our members' part to have their own system for ensuring appropriate medical care. It also was a response to the numbers of other organizations trying to define quality, cost-effective care.

Doctor Mandell

"I invite you to read the following pages in which MSMS presents a review of quality of care trends."

- Several of the 1987 MSMS delegates' resolutions sought to provide physician contributions to the processes reviewing physicians' care. They dealt with the Michigan Peer Review Organization and managed care plans.
- For years, MSMS has worked with the Michigan Physicians Mutual Liability Company to help physicians monitor their own delivery of care through risk management programs.
- In 1986, MSMS founded the Medical Associations for Risk Management (MARM), to gather statistics and provide educational materials on areas where physicians must be especially careful.

As president of MARM, I am pleased to draw your attention to two MSMS seminars this month in Farmington Hills and Grand Rapids. These Medical Malpractice/Risk Management Seminars are planned May 11 and May 12 through MARM and another MSMS subsidiary, Physician Service Group, Inc.

The seminars, which will be duplicated at later dates in other locations, discuss malpractice trends; physician-patient communications; collection, billing and insurance processes; informed consent issues; medical record-keeping; malpractice cases related to office system weakness, and office risk management.

The seminars are designed to further pursue the quality of care in our own profession. They are examples of the help MSMS is offering its members. We urge you to take advantage of them in future months. Watch *Medigram* for further details.

To continue the discussion, I invite you to read the following pages, in which MSMS presents a review of quality of care trends.

Much of the material here was generated at the recent MSMS Hospital Medical Staff Section annual meeting, where quality of care issues were the theme. Much relates to delivering quality care in the hospital setting.

Future articles will deal with delivering quality care in the physician office setting.

Please read on, and comment, or respond, if you will. *Michigan Medicine* welcomes your letters and opinions. ☐

Doctor Mandell is vice president for medical affairs at Sinai Hospital, Detroit.

MSMS HMSS members discuss quality of care issues

By Ruthmarie Shea-Atallah

Editor's note: The following article highlights several presentations given at the fourth annual meeting of the MSMS Hospital Medical Staff Section March 19 in Dearborn. The theme of the meeting was "Quality Assurance for the 1990s."

An agenda for change

There is an underlying belief by Business and Government that health care quality can be measured statistically. Experience has shown, however, that the statistics can be grossly misleading. For example, an institution's operative mortality, infection and complication rates, though easily measured, are imprecise parameters and do not necessarily reflect an institution's overall quality.

The solution: health care institutions must show Business and Government how to better measure quality, William Jessee, MD, vice president for education, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), told members of the MSMS Hospital Medical Staff Section in March.

To do this, information must be gathered, Doctor Jessee said. "Frequently, the predicted rate of a particular undesirable outcome cannot be found in the literature. These rates have not been determined. The only way to find out what to expect is by collecting data."

The author is a Detroit-area freelance writer.

In response to the need for reliable data, Doctor Jessee said JCAHO has committed to an "Agenda for Change." The accreditation process in the 1990s will be based on performance evaluation, he said. JCAHO, which currently accredits over 5,000 hospitals and 3,500 other health care institutions, will evaluate a facility's clinical performance as well as the effectiveness of its organizational functions.

Health care institutions must show. . . how to better measure quality.

Doctor Jessee said JCAHO hopes to assure adequate physician input in each organization, and will evaluate the facility's communication with its physicians and specialty societies. Data collection within the facility will also come under scrutiny. Development of "clinical indicators" within each institution is already required. Indicators may be "things you wouldn't expect to have happen or things you expect to see always," Doctor Jessee said. National indicators will be used by the Joint Commission in its new process beginning in 1990, he noted.

Indicators are now being pilot tested for obstetrics, anesthesia, and "hospital-wide" performance. Results will be available in late 1988. By 1989, a larger scale test in 100 hospitals will be underway using these clinical indicators. Other clinical indicators are currently being developed for areas such as oncology, cardiovascular care, trauma, and general surgical care. Analysis of the findings of these pilot tests will generate reliable statistics on predicted ranges of outcomes which will then be used as part of the accreditation process, Doctor Jessee concluded.

Quality assurance requires staff input, peer review

Quality assurance is an ongoing task; it requires the active participation of all staff members on a daily basis, said Gerald H. Mandell, MD, vice president for medical affairs at Sinai Hospital, Detroit.

To assure quality at Sinai, Doctor Mandell said the hospital has assembled a multidisciplinary team comprised of a registered nurse, associate administrator, risk manager, attending physicians, lawyer and officers of the medical staff executive committee. Its quality assurance manager examines procedures throughout the hospital to determine if they meet quality assurance standards.

Continued on next page

HMSS/Continued

In addition to the active participation of all staff members, Doctor Mandell said health care facilities need "standards, criteria of care and follow-up." Standard procedures can be evaluated to determine compliance. Sometimes all that is needed to maintain quality is to let others know that someone is watching, he said.

Peer review has flaws

Peer review is one method of assuring quality care, but it has flaws in its design and implementation. "You can't make improvements if you only inspect for quality at the end; it has to be built in as the care is delivered," Doctor Jessee said.

Peer review committees have typically failed to generate an atmosphere of goodwill, and instead have focused exclusively on the negative. "When was the last time any of you received a letter from your hospital's peer review committee commending you for a job well done?" Doctor Jessee asked.

"In the current peer review process there are generally only two categories to choose from: standards of care met or standards of care not met. Most people don't want to commit themselves to a 'not met' designation. This ultimately defeats the purpose of review and leads to analysis paralyisis," he continued.

Doctor Jessee said the JCAHO wants to see a shift away from this yes-or-no mentality to a system that encourages looking for "what could have been done better." It is possible to take the perspective that quality is never good enough and always can be made better, he concluded.

Legal immunities granted for peer review bodies

A new federal statute, Public Law 99-660, Federal Health Care Quality Improvement Act of 1986, provides substantial legal immunities for peer review bodies, members of peer review bodies, persons under contract with the body and persons assisting the review body. Monte Jahnke, attorney at law, Kerr, Russell and Weber, states this law "is a political response to protect the peer review process from some antitrust exposure."

> **"Anti-trust laws do apply to hospital settings to the extent that what you say can impact on somebody's ability to earn a living."**

Always a matter of some concern to professional peer review members is the threat of legal liability attaching an unfavorable review, said Jahnke.

"Anti-trust laws do apply to hospital settings. . . to the extent that what you say can impact on somebody's ability to earn a living," he said.

The review committee must meet certain guidelines and standards in order to assert these immunities. The law also imposes the duty to give notice and disclosure to the physician. The actions must be taken with a reasonable belief that it is to further quality health care. A reasonable effort must be made to ascertain the facts. Adequate notice must be given along with a description of the proposed action and the reasons for it. The hearing must be held in front of a neutral hearing body. The individual against whom the action is contemplated is allowed representation by counsel, cross-examination of witnesses, presentation of evidence and a written determination of outcome stating the basis for recommendations issued.

The net result of this is that the physician subject to sanctions will know sooner, have a clearer understanding of the issues involved and have access to legal counsel. The peer review organization, after fulfilling its obligation of notice and disclosure, will have a broad measure of immunity for actions undertaken in good faith and reasonable belief.

This act provides protection to individual physicians and review committees alike. Jahnke said he believes it will foster openness, problem-solving and an increased degree of candor. ☐

HMSS Annual Meeting highlights

At the opening of the MSMS Hospital Medical Staff Section meeting March 19 in Dearborn, the HMSS Delegate to MSMS, Krishna K. Sawhney, MD, right, discussed resolutions with, from left, Gilbert B. Bluhm, MD, president, Wayne County Medical Society, and Marsha Milburn, MD, Ingham County delegate to the HMSS. Quality of care issues were the meeting theme.

Continued on next page

Excitement ahead, HMSS chairman predicts

By Judy Marr, editor

"The future looks to be very exciting for this group," said Gary D. Maynard, MD, chairman of the MSMS Hospital Medical Staff Section, at the group's annual meeting on March 19.

Doctor Maynard offered two reasons for his optimistic forecast. First, in many areas of the state, hospital medical staffs are more active and stronger than the county medical societies. Secondly, MSMS delegates in the metropolitan Detroit area are tied more closely to their hospital medical staffs.

For these reasons, said Doctor Maynard, MSMS Board Chairman Robert E. Paxton, MD, has asked him to propose ways in which MSMS can work more closely with hospital medical staffs.

One of the considerations, Doctor Maynard noted, is to find ways for all of the state's hospital medical staffs to be more actively represented in the MSMS House of Delegates.

The HMSS also is considering a speakers' bureau to address interested physicians about hospital medical staff issues, such as peer review, medical liability and HMSS bylaws provisions.

The HMSS, now four years old, has had a good year, according to Doctor Maynard. It has:

- Developed a promotional brochure;
- Cosponsored the 1987 annual Michigan Staff-Trustee-Administrator Forum;
- Developed, with the Michigan Hospital Association, two teleconferences on marketing physicians' practices;
- Cosponsored a seminar on leadership strategies;
- Successfully promoted creation of the MSMS/MPRO Liaison Committee;
- Advocated self-help groups for physicians in litigation;
- Sent one of the largest state delegations to the AMA Hospital Medical Staff Section meeting.

"The HMSS is a direct link between MSMS and medical staffs around the state," said Doctor Maynard. "The HMSS is a vehicle for medical staffs and MSMS to use in discussing respective needs and interests. HMSS representatives serve as key facilitators for their medical staffs.

"We have had a good year, but the HMSS needs to grow and do more for medical staffs," said Doctor Maynard. "We cannot do this without the involvement of committed physicians."☐

Members of the HMSS Governing Council, from left, are Peter A. Duhamel, MD, Oakland County, member-at-large of the Michigan and AMA Hospital Medical Staff Sections; Krishna K. Sawhney, MD, delegate to MSMS; Gerhard C. Endler, MD, secretary; Harry Doerr, MD, alternate delegate; Dorothy M. Kahkonen, MD, outgoing member-at-large; Gary D. Maynard, MD, chairman, and John A. Rupke, MD, member-at-large.

Gerald H. Mandell, MD, Detroit, described the quality care advances at Sinai Hospital of Detroit, where he is vice president for medical affairs.

Photos by Ronald Ponkey

The delegates heard a luncheon address by William Jessee, MD, vice president for education of the Joint Commission on Accreditation of Healthcare Organizations.

HMSS HIGHLIGHTS/Continued

SPECIAL REPORT

Pitfalls in practice

By Donald H. Kuiper, MD

Editor's note: The following article appeared in the September 1987 issue of the *Federation Bulletin* and is reprinted with the permission of the editor and author.

Having just completed eight and one-half years of service on the Michigan Board of Medicine, I want to share some areas with you in which physicians have gone astray and which have resulted in disciplinary action being taken by the Board of Medicine, which has responsibility for the protection of the health and safety of the people of Michigan.

The objective of this article is to alert physicians of areas that require their attention in the practice of medicine. One of my impressions is that some physicians have gotten into difficulty with the licensing board because of ignorance regarding standards of practice. It is well known that prescription drug abuse is a widespread problem in the United States. Sloppy prescribing habits of physicians contribute greatly to this problem. A typical example has to do with the area of prescription renewal. A pitfall that I have noted on several occasions in the State of Michigan is exemplified by the following scenario.

A physician may have a number of patients call the office for prescription renewals; typically the nurse or medical assistant may save these until the end of the day for action by the physician. In some cases, the physician might just authorize the nurse to call the pharmacy to renew the prescription, or the office may have no policy whatsoever regarding prescription renewals.

With the increasing public awareness of prescription drug abuse, it is entirely possible for regulatory agencies to monitor controlled substance distribution through pharmacies. If a trend is noted where excessive amounts of controlled substances are being prescribed and dispensed for an individual, this may lead to an investigation by enforcement authorities.

One area of abuse is the patient obtaining controlled substances from his/her physician only to be selling or distributing these to other individuals who are addicted. A typical example is: a patient will call the office for a refill on Talwin and the prescription reads, "Talwin sig. one tablet, q.i.d., #28" and "no refills." If this medication is taken according to the directions, the quantity should last for at least seven days. However, if the patient calls back in three days for a refill, this should immediately alert the physician that there is a potential problem and the medication should not be refilled. In a busy office practice, however, where refilling prescriptions with pharmacies is delegated to a nurse or medical assistant without the careful attention of the physician, this may lead to abusive prescribing habits.

Another area of abuse is on a weekend or holiday call system where a covering physician is contacted by telephone to renew a medication. One must be care-

Continued on next page

Doctor Kuiper is past chairman of the Michigan Board of Medicine.

PITFALLS/Continued

ful about this and should either examine the patient prior to prescribing or give just enough medication to allow the patient to cover the period during which the doctor is on call. A good rule to apply in the office would be that no medications are refilled if the patient hasn't had a physical examination at least every 12 months. This should be a good policy to build into the office rules.

The problem of stolen prescription pads, of course, is well known and prescription pads should not be left in the examination room. A good practice is for the physician to keep one in his/her coat pocket, or the pads should be locked in a drawer in the physician's office. Also, the DEA number should not be printed on prescription pads or stationery.

Another pitfall that has been discovered is poor record keeping. Be sure that what is prescribed is recorded and again emphasize the rule that no refills of any type are allowed unless the patient is seen in the office for at least a yearly examination.

An additional area of concern is prescribing for a relative or a spouse. It is urged that physicians not prescribe for relatives or spouses since their objectivity and judgment may not be pure. Also, prescribing for oneself is a hazardous practice and should not occur except in extreme emergencies.

In the State of Michigan one must be in possession of a special license to prescribe for the detoxification of known addicts. I have encountered a number of physicians who have prescribed controlled substances for individuals who were known to be addicted and during the hearing process before the Board of Medicine, the argument was frequently given, "I was only trying to help them out." One should research his state laws very carefully to avoid getting caught in this trap. Addicted patients are best referred to a recognized detoxification program.

> **"One of my impressions is that some physicians have gotten into difficulty with the licensing board because of ignorance regarding standards of practice."**

Another common pitfall that can get the doctor into difficulty is absent or poor documentation of what was done for the patient. It may be in the area of prescriptions, history, physical findings and/or laboratory data. This is not only below minimal standards of good practice but it also opens the door for adverse outcomes and litigation if one's motives in submitting claims to third party carriers are ever questioned. It is also difficult to determine why certain things were not done. Omitting a part of an examination is another area that may cause difficulty.

In the area of medical office management and procedures there are a number of pitfalls. One should be alert as to what is being billed to third party carriers. The blind application of one's signature to insurance forms can lead to difficulty if inaccurate codes are placed on the procedure. I recall a physician who was submitting claims to a third party carrier for procedures that were never done on the patient for whom the claim was filed. One careful investigation of this doctor's office, it became apparent that the wrong names were being matched with the claims.

It is very important that physicians be aware of what office staff are doing on your behalf. Earlier in this article reference was made to controlled substance and prescription renewals. This also applies in the area of appointments, information given out to patients' insurance carriers, attorneys, etc. One should be alert as to who submits bills in your name. We encountered a situation in Michigan where a doctor was employed by a clinic and this clinic also employed social workers who resided in a town some 50 miles away. Claims were being submitted to a third party carrier in the name of this physician who never saw any of the patients for whom the claims were submitted. The social worker was the only one who had any contact with the patient. One must also be careful that claims to third party carriers are submitted only in the name(s) of those individuals who are eligible to be covered. For example, if a husband and wife are covered under different healthcare insurance policies, and one policy has expired, it is illegal to file a claim on behalf of the patient with the expired policy under the claim of the spouse whose insurance is still in effect.

Another area where physicians have gotten into difficulty has been billing a third party carrier for time which was scheduled or appointments that were not kept. It is ethical to bill third party carriers only for services rendered, not for scheduled unkept appointments.

The objective of this article has been to share with you some of my experiences as they relate to areas where physicians have gotten into difficulty with a state board of medical examiners, specifically the Michigan Board of Medicine. In most cases the intent of the physician was good; however, due to ignorance of the law, sloppy procedures, poor judgement or too great a workload, there was a breakdown in the general discipline of the practice which resulted in offenses which led to disciplinary action against the physician. ☐

Quality assurance programs a must for MD office labs, says ASIM

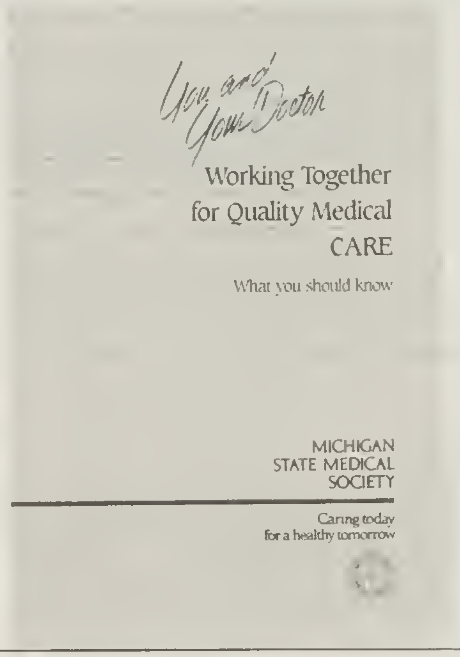
All laboratories, including physician office labs, should be required by the federal government to participate in appropriate quality assurance activities, the American Society of Internal Medicine (ASIM) told members of the U.S. Senate's Committee on Governmental Affairs' Subcommittee on Oversight of Government Management during its March hearing on the federal government's role on assuring the quality of medical laboratory testing. However, applying the same standards for independent labs to physician office labs — as could happen under a provision enacted as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA'87)—would have a tremendous negative impact on patient access to appropriate laboratory testing in physician offices. ("Independent labs" generally refers to large commercial labs that process tests on patients referred to them by physicians.) Instead, believes ASIM, all physician office labs should be required to participate in appropriate, specially-designed and approved proficiency testing and accreditation programs.

For a copy of ASIM's statement, which includes a white paper on the advantages to patients of in-office lab testing, call the ASIM office at (202) 289-1700. ☐

MSMS brochure addresses quality medical care

Choosing and evaluating a physician can be a difficult task for patients seeking quality medical care. MSMS members can help make that task easier by utilizing a new MSMS brochure entitled, "Working Together for Quality Medical CARE."

MSMS members are entitled to one free copy of the brochure. Each additional copy costs 20 cents. Quantity discounts are available. To order the brochure, or for more information, contact the Communications and Professional Relations Department at MSMS. ☐



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SPECIAL REPORT

We must take an active role in providing quality care

By Janet K. Baum, MD

Editor's note: The following article appeared in the March 1988 issue of the Washtenaw County Medical Society *Bulletin*, and is reprinted with the permission of the editor and author.

Despite disagreements on how well the Michigan Board of Medicine functions and who should be in charge of licensure and discipline of physicians and the quality of medical care in this State, the three panel members at the February Michigan Board of Medicine general session meeting agreed that all physicians need to be aware of quality of care being delivered in our communities.

If we are ever to solve the malpractice insurance crisis, we must all take an active role in making sure that the quality of medical care provided in Michigan is uniformly high. Whether the state, through the Board of Medicine and state funding, or organized medicine, through the medical societies, specialty societies, and hospital review committees, has the ultimate responsibility and authority to review and discipline individual physicians will not really matter unless each of us does our part.

The Board has some very dedicated physicians who try to impartially and carefully review all cases brought to their attention. Many complaints do not reach the full Board for evaluation. A perfect system for review of all complaints received by the Board may not exist but at least some review with due process for those reviewed is present.

Perhaps MSMS could provide support for pre-review evaluation of all cases presented to the Board with initial review provided by members of the appropriate specialty groups. The Board of Medicine may need to function independently of the Attorney General's office and a public audience for at least part of the review process. Perhaps the Board's functions and even the Board, itself, should be run by the State Medical Society.

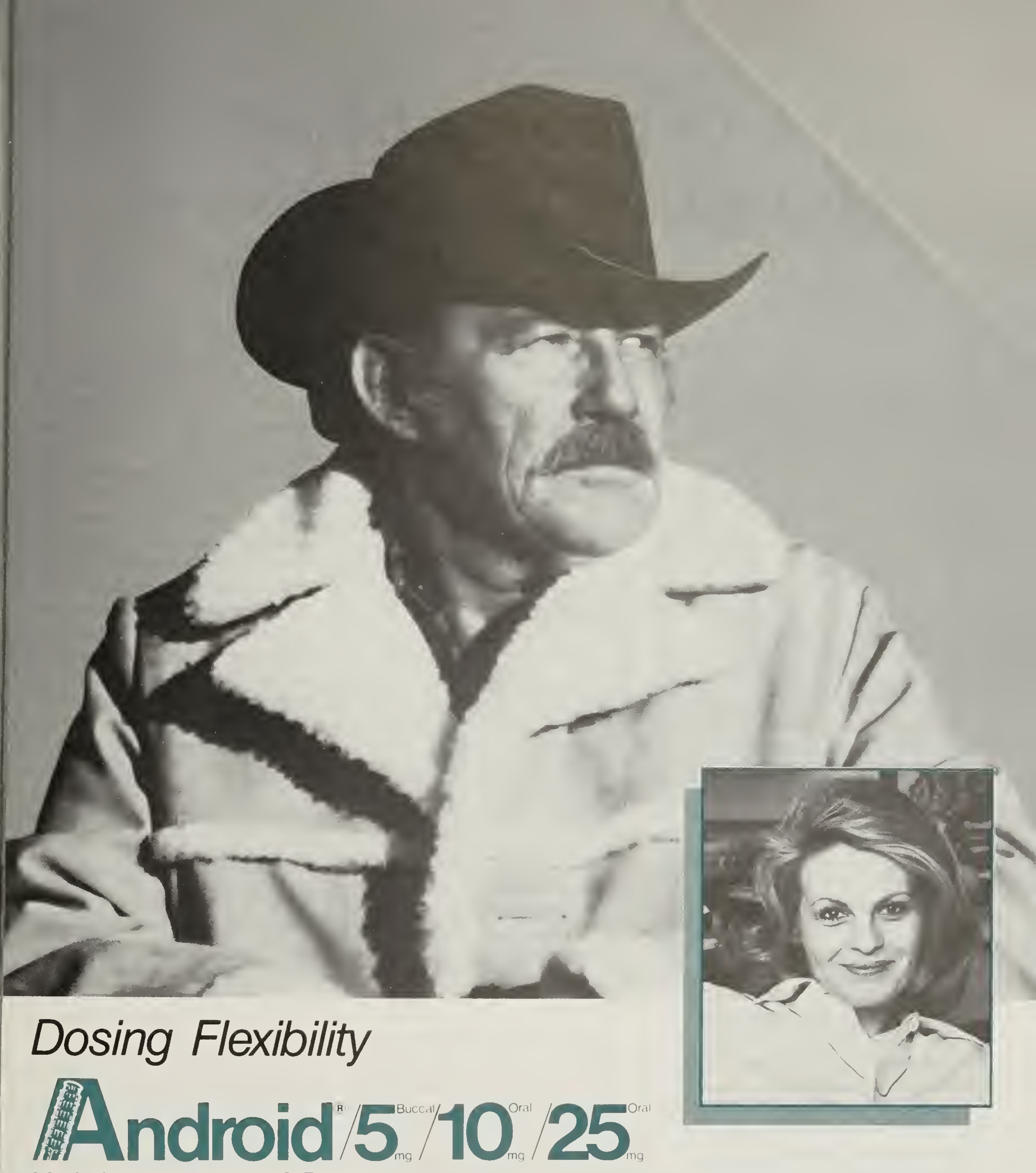
> "If we are ever to solve the malpractice insurance crisis, we must all take an active role in making sure that the quality of medical care provided in Michigan is uniformly high."

No matter how the licensure and discipline of physicians is accomplished, effective evaluation of quality of care and the ethical and moral behavior of physicians cannot be carried out without involvement of each and every one of us. We all need to be aware of our colleagues' practice patterns as well as their behavior. If we have questions about the practices of a colleague or are concerned that a colleague might be impaired, we cannot afford to ignore these questions. Reporting these concerns to the appropriate hospital medical staff committee, the county medical society, a specialty society or even the Board of Medicine, is our responsibility in order to help maintain good medical care in Michigan.

We are not doing a good enough job yet in policing ourselves. Only a very small number of cases brought to the Board of Medicine's attention are brought by physicians or physician committees. Too many of us are too busy to serve on hospital or society review committees. Not enough of us are willing to take the time to become involved in what can often be a difficult, time-consuming, and emotional process.

Despite some disagreements among the panelists at the recent general session meeting, there was agreement that every physician must become involved in evaluating the type of care we provide. Unless physicians take responsibility, others will do it for us and we will all suffer the consequences — such as more extraneous controls on our practices, more malpractice suits, and a further worsening of the image of our profession. ☐

Doctor Baum is an Ann Arbor diagnostic radiologist and is president of the Washtenaw County Medical Society.



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FAS persists despite broad public awareness

By Patrick Fitzgerald

When Bay City obstetrician/gynecologist Bernhardt Pederson, MD, began practicing in 1964, no one asked about fetal alcohol syndrome (FAS), now one of the leading known causes of mental retardation. “Today, it is one of the most common questions I hear,” Doctor Pederson said. “If I don’t bring it up, the patient almost always does.”

Most women know about the potential risks of drinking alcohol while pregnant. Since the discovery of FAS in 1973, scientific researchers have conducted thousands of studies and issued thousands of reports. The U.S. Surgeon General and the American Medical Association have publicly recommended abstinence from alcohol for pregnant women, and women who plan to become pregnant, to eliminate any risk of FAS afflicting their babies. Government and private agencies continue to sponsor public information campaigns to alert women to the dangers of FAS.

Studies, official warnings and publicity have certainly raised the public’s awareness of FAS. But there is no evidence that heightened awareness has led to a reduction in the number of FAS births, according to Robert Sokol, MD, chairman and chief of the Department of Obstetrics and Gynecology at Wayne State University’s School of Medicine/Hutzel Hospital.

The author is a Detroit-area freelance writer.

“What we really need to do is to identify the people who are most at risk and work with them,” Doctor Sokol said. “We need more information about the problem so we know who is susceptible. It appears that some fetuses are considerably more susceptible than others to damage from prenatal alcohol exposure . . . Dose for dose, (black fetuses) are more likely to be affected than white infants. This suggests a genetic basis for this differential effect.”

Nationally, an estimated 40,000 babies are born each year with alcohol-related birth defects. In Michigan, FAS births are estimated at 400 annually. FAS infants are characterized by facial malformations, joint and limb abnormalities, heart and muscle problems, low birthweight, growth deficiencies and serious central nervous system problems that can lead to mental retardation.

FAS symptoms are the most extreme of alcohol-related birth defects. Prenatal exposure to alcohol also increases the risks of spontaneous abortion, stillbirth, anatomic congenital anomalies, intrauterine growth retardation and neurobehavorial abnormalities, according to Doctor Sokol, one of the nation’s leading FAS researchers. A national center for FAS research, Wayne State recently received a $6 million federal grant for five more years of FAS research. Doctor Sokol estimates the cost of alcohol-related birth defects at more than $300 million annually.

Risk detection difficult

“We have been working on this for 10 years, and we have learned a lot since 1973. But we still need to learn more,” said “Doctor Sokol. “Part of the problem lies in risk detection. As many psychiatrists are well aware, and many individuals involved in prenatal health are learning, risk drinking is very difficult to detect. There are no laboratory tests that are sensitive and specific enough to make the diagnosis. Obtaining an appropriate history is necessary, but difficult because of denial.”

Doctor Sokol said heavy drinking women represent the “lion’s share” of those at greatest risk. “Abusive drinking among women of reproductive age is typically in the 3 percent to 4 percent range, whereas full FAS occurs with a frequency of .19 percent. Recent studies have indicated that the threshold for full FAS is over six standard drinks per day, an amount imbibed by less than one percent of pregnant women," he reported.

But researchers still have not answered the question of "how much is too much" exposure to alcohol and in the absence of such scientific evidence, Doctor Sokol said he believes physicians should advise abstinence. "As a physician, I think (abstinence) is the message we should give our patients — that alcohol is not good for man or beast during pregnancy.

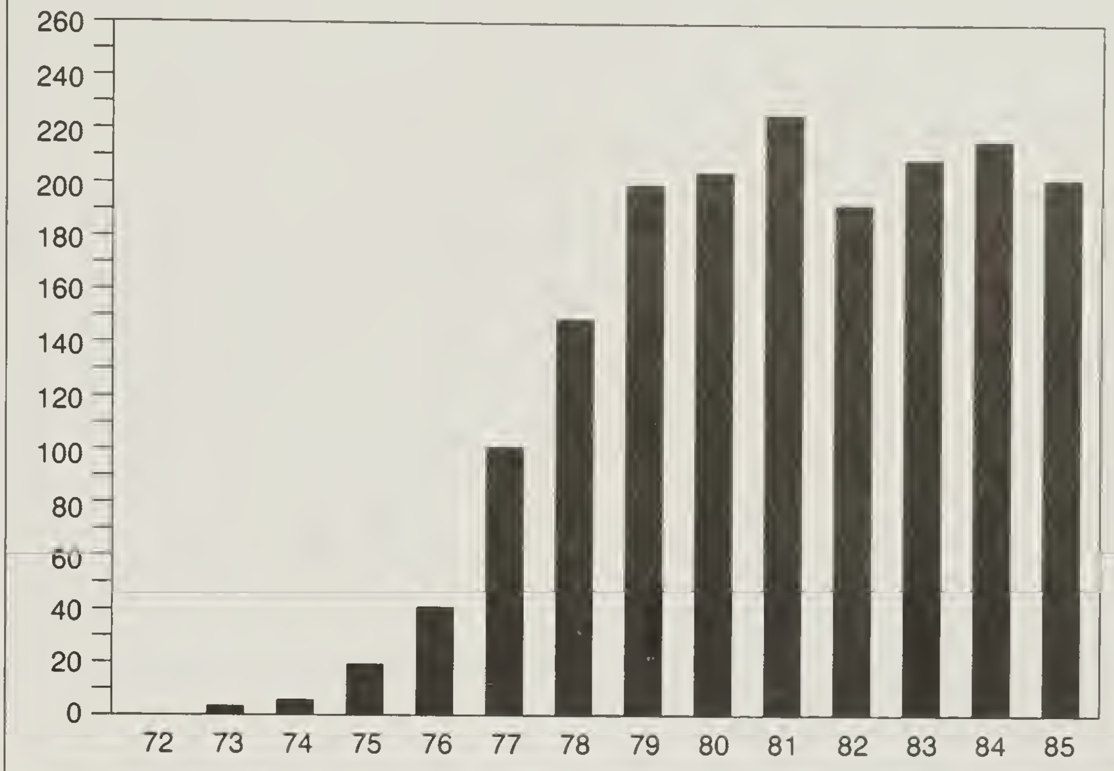

Figure 1. — Almost 2,000 publications on the fetal alcohol syndrome have appeared in scientific and medical journals since 1973, the year when descriptions of FAS as a distinct clinical entity were first published by dysmorphologists at the University of Washington. As shown in the graph, a very steep rise in publication rate occurred between 1973 and 1979. Since that time, the rate has remained fairly steady at around 200 per year.

Source: Database of the National Clearinghouse for Alcohol Information.

No drinking is best advice

In the context of today's medical/legal climate, Doctor Pederson said he recommends advising patients against drinking any alcohol at all.

"Every step we take we have (the threat of medical malpractice lawsuits) hanging over our heads," he said. "It influences everything we do. The problem is that scientific reasoning flies out the window. Moderate drinking may not be a problem. But I would never say that to one of my patients. No one knows exactly what the incidence is. The simplest thing is to tell them to avoid alcohol completely."

Doctor Pederson estimates he has delivered more than 5,000 babies during his career. Pregnant women seldom object to advice to forego alcohol but often ask whether it is okay to have a glass of wine with dinner. "I tell them no," Doctor Pederson said.

Despite broad general awareness of FAS, many women believe that moderate drinking is not a threat, according to Eugene Delansky, MD, a Michigan State University professor and Director of Neonatology at Sparrow Hospital in Lansing. But Doctor Delansky said he believes pregnant women should refrain from drinking even small amounts of alcohol because statistics suggest that alcohol-related damage occurs as frequently as once in every 400 to 500 births. "Moderate drinking might be risky," he said. "One binge alone at the wrong time can lead to consequences."

Embryonic exposure is the problem, according to a report by Doctor Sokol on preventing and detecting fetal alcohol effects. "Right around the time of conception is the 'critical' period teratologically speaking. This periods extends from approximately four to ten weeks' conceptual age, a considerable portion of which occurs prior to a woman's recognition that she is pregnant."

Preventing FAS is complicated by the reluctance of heavy-drinking pregnant women to tell physicians the truth about how often and how much they drink,

Continued on page 264

SYNDROME/Continued

according to Doctor Sokol. "Substantial under-reporting of alcohol use during pregnancy occurs, particularly among women with a history of alcohol-related problems," he said.

A call for action

"We very badly need a practical, simple, brief set of questions which would allow detection of risk drinkers without triggering denial."

According to Doctor Sokol, such a questionaire would have to be sensitive enough to alert physicians to possible problems. It would be administered to non-pregnant women of reproductive age and to women in early pregnancy. "Failing the current availability of such a questionaire, the clinician must fall back on working an alcohol history into his or her routine OB/GYN history," he said.

Doctor Delansky believes the solution is to have physicians

> "We very badly need a practical, simple, brief set of questions which would allow detection of risk drinkers without triggering denial."

Continued on page 268

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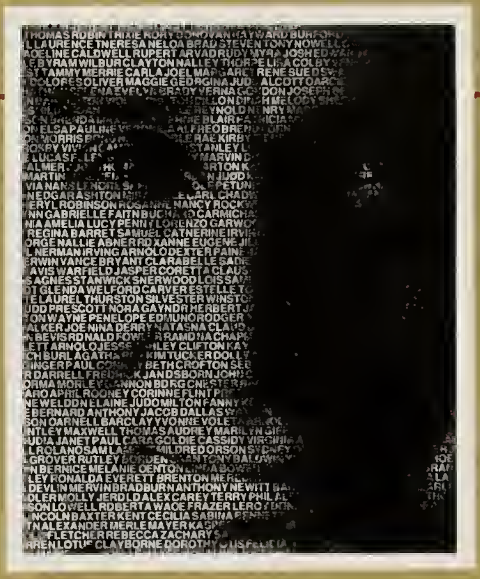

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Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

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(PROPRANOLOL HCl)

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Please see next page for brief summary of prescribing information.

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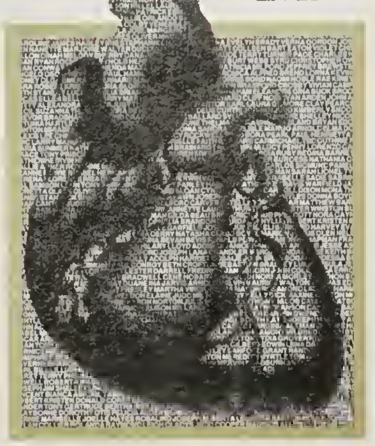

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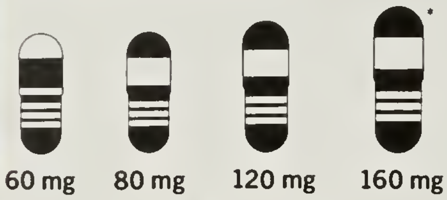

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have *not* been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized*. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized*. Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized*. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Reference:
1. Data on file, Ayerst Laboratories.

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SYNDROME/Continued

focus attention on prevention programs for teenage girls.

"True alcoholism in women is increasing," he noted. "Nationally, there are 2.5 million chronic alcohol ingesters of child-bearing age. We are seeing more teenage pregnancies and more substance abuse by young people. I've seen statistics that say one-third to one-half of students in the seventh, eighth and ninth grades consume some alcohol and teenagers who drink alcohol are more likely to become pregnant than those who don't."

Government-sponsored campaigns

Government-sponsored public information campaigns appear to have narrowed their focus recently, devoting special attention to younger women and those from lower socio-economic environments. FAS information is available to the public as well as to physicians. Current examples include:

A comprehensive folder on ***Substance Use and Pregnancy: Professional and Patient Resources.*** Single copies are available at no cost from the National Maternal and Child Health Clearinghouse, 38th & R Streets, N.W., Georgetown University, Washington, D.C. 20057. (202) 625-8410.

Alcohol and Birth Defects: The Fetal Alcohol Syndrome and Related Disorders and ***Program Strategies for Preventing Fetal Alcohol Syndrome and Alcohol-Related Birth Defects.*** U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, National Institute on Alcohol Abuse and Alcoholism, 5600 Fisher Lane, Rockville, Maryland 20857.

> **"If we can find them, many heavy-drinking pregnant women can and will stop drinking. Physicians really can do something about it." — Doctor Sokol**

State lawmakers active in FAS issue

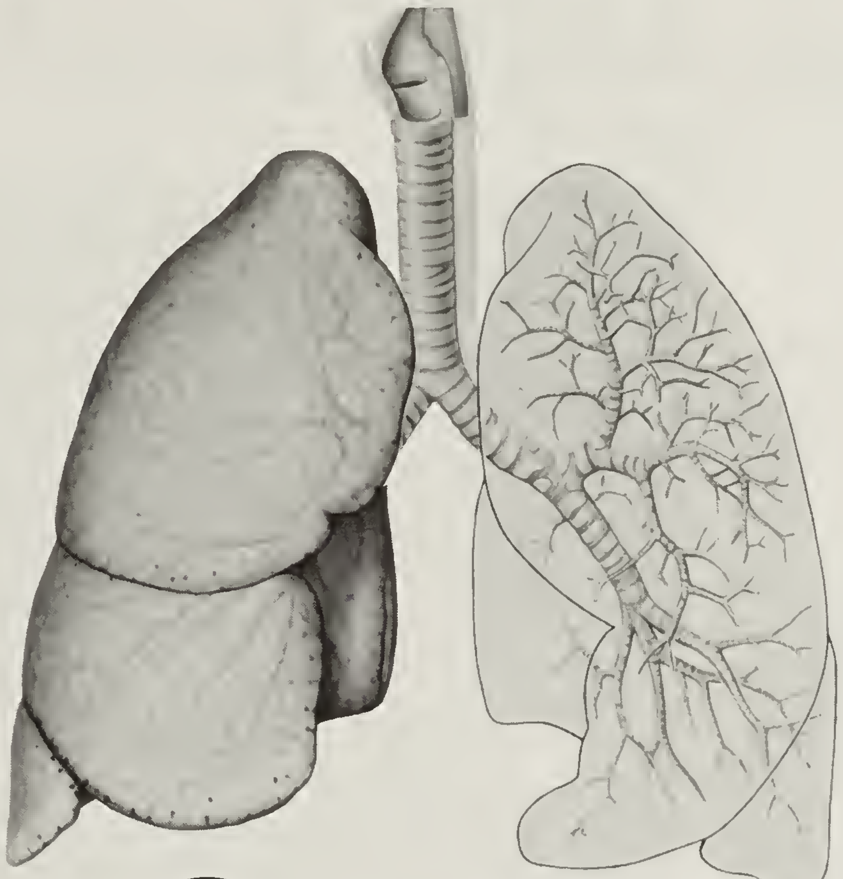
State lawmakers are taking increasing interest in FAS. Wisconsin lawmakers last year enacted legislation requiring county clerks to distribute FAS education pamphlets to marriage license applicants. Utah, Georgia and South Dakota require alcohol retailers such as party stores and restaurants to post signs warning against drinking during pregnancy. Cities such as New York, Los Angeles, Philadelphia and Washington have adopted similar ordinances.

William M. Sokol, MD

In Michigan, State Representative Mary Brown, (D-Kalamazoo) is considering legislation to require physicians to distribute FAS information pamphlets to patients and to post FAS warning signs in offices and clinics.

"My personal thought is that it is unlikely that legislation will be of any value at all," Doctor Sokol said. "FAS and alcohol dependence are medical problems that are not likely to respond to legislation. If we can find them, many heavy-drinking pregnant women can and will stop drinking. Physicians really can do something about it. Patients listen to their doctors and I believe there are real opportunities to practice good prevention in our offices." ☐

Consider the causative organisms...



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Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly). [061787L]

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Frederick W. Bryant, MD — new MSMS president

By Betty J. McNerney, Managing Editor

By the time he graduated from his small-town high school in Michigan's Keweenaw Peninsula, Frederick W. Bryant, MD, knew that he one day would become a doctor. "I had a conference with my parents when I was about 12 years old about the career options I had and what college preparatory courses I should take in high school," he said. While both his parents (his father a dentist, his mother a teacher) were careful not to force him into anything, Doctor Bryant said his dad pointed out to him "the quality of people you meet in the professions."

And so, after graduating from high school, Doctor Bryant began his premed education at the Michigan College of Mining and Technology, now Michigan Technological University, in Houghton. After studying two years at Michigan Tech, Doctor Bryant attended the University of Michigan ("a Bryant tradition") where he earned both his baccalaureate and medical degrees.

While he one day would choose ophthalmology as his profession, Doctor Bryant had other choices and interests. "The intricacies and complexities of psychiatry have always been fascinating to me," he said.

General surgery also was an option.

Choosing ophthalmology "was quite by accident," according to Doctor Bryant. "The opportunity came to me (while a surgical resident at St. Joseph Hospital in Milwaukee) when my roommate discovered there was an ophthalmology vacancy (at Presbyterian Hospital) in Chicago," he said.

Doctor Bryant sits comfortably in his Royal Oak office. Behind him is his 128-volume collection of books on the history of the Civil War.

That "accident" led Doctor Bryant to 30 years of private practice as an ophthalmologist in Royal Oak. But there is more to his story.

Following his ophthalmology training at St. Joseph Hospital, Doctor Bryant was called to the Orient to serve as a Naval Lieutenant during the Korean War — an experience which had the potential of changing the course of his medical career. But, the military did not appeal to him as a way of life. "I really think of myself as being too anti-authoritarian to be a good military enlistee," he said. "I want to set my own standards and live at my own pace."

After working two years at a remote Montana clinic following the war, Doctor Bryant knew he needed to practice ophthalmology on his own. "There were several good things about working in the clinic," he reminisced. "But, after I had been there awhile, the staff started arguing about how many plaques we could have on the wall and that we could only have three weeks

Continued on page 272

It Shouldn't Even Be a Contest

You want what's best for your patients — not what's cheapest. Medicine shouldn't be practiced any other way.

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In Washington, D.C., and in court, we're fighting government-imposed fee freezes and other attempts to restrict the rights of physicians and patients.

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BRYANT/Continued

vacation time per year. I wanted more time for myself."

As a solo private practitioner, and bachelor, Doctor Bryant has all the time he wants and needs. In fact, he sets aside three months each year for travel. A life-long student of history and geography, Doctor Bryant has traversed all 50 states in search of the scenic and cultural landmarks of the nation. A Civil War buff, Doctor Bryant has managed to visit all the major battlefields of the War. When he gets the chance, he refers to his more than 600 books on the Civil War.

History and travel aside, Doctor Bryant has served — and continues to serve — the medical community in a variety of ways. Locally, he has participated for several years in the teaching programs at both Grace and William Beaumont Hospitals. In addition, he is a member of the Oakland County Medical Society where he has served as president, Delegate to the House, and three-term Representative from the Fifteenth District (Oakland and Macomb counties) to the MSMS Board of Directors. He just completed a two-year term as president of the Michigan Ophthalmological Society.

Over the years, Doctor Bryant has served on several MSMS committees. Currently, he is chairman of the AIDS Education Task Force, the Bioethics Committee and the Committee of Specialty Society Presidents, as well as a member of the CME Programming Committee, Liaison with the State Bar, Planning Committee for the Annual Scientific Meeting, Policy Manual Committee, and a member of the Board of Directors of the MSMS subsidiary, Physician Service Group Inc.

Doctor Bryant feels honored to serve on these MSMS committees, since many deal with delicate and/or controversial medical issues. "I look upon it as a lefthand compliment that someone thinks highly enough of me to ask me to serve MSMS in this way," he said.

Doctor Bryant is equally honored to be the 123rd president of MSMS. While he said he has no specific project which he plans to pursue, he identified AIDS as "the chief medical challenge of the day," and said it is a devastating disease that requires our attention."

His goal as MSMS president is "a social one, a human one," Doctor Bryant said. "My campaign for president was more one of communication and friendship and maybe projection of sincerity and productivity than it was one of promoting a particular project," he said.

"When my year is over, I want to be remembered as having been a competent medical leader, yes, but also as a good guy and loyal friend."☐

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Maternal and Perinatal Health Conference highlights

By Betty J. McNerney, Managing Editor

Carl A. Gagliardi, MD, MSMS president, kicks off the first general session of the 27th Annual Michigan Conference on Maternal and Perinatal Health, March 23-24, at the Amway Grand Plaza Hotel in Grand Rapids.

The Michigan Conference on Maternal and Perinatal Health drew more than 600 attendees. In addition to several scientific courses and exhibits, the two-day conference featured an afternoon of stimulating sessions on medical ethics.

"The idea of going to court or being sued is part of doing business. . . it is a reality of practicing (medicine) in this country," Carol J. Harvey, RNC, MS, told attendees at a luncheon session on the "Common Areas of Negligence in Electronic Fetal Monitoring." The best defense in a court of law, according to Harvey: knowledge. Document administered care, "show the courts that you are thinking," she advised.

Chairs were hard to come by at the Thursday luncheon discussion on "Common Areas of Negligence in Fetal Monitoring." Attendees at this soldout luncheon learned about a variety of strategies to help decrease liability in fetal monitoring. Chief among them is careful documentation of administered care. In a court of law, "the chart becomes the case," said featured speaker Carol J. Harvey, clinical nurse specialist, Department of Obstetrics and Gynecology, at the University of Tennessee at Memphis. "The chart is the witness that never lies and never dies," she said.

The first morning of the conference featured four speakers. Pictured from left to right are: John M. Grostic, JD, an attorney with Smith, Haughey, Rice and Roegge, of Grand Rapids, who discussed, "Legal Implications of Primary Perinatal Practice"; John V. Hartline, MD, president, National Perinatal Association, and neonatologist, Bronson Methodist Hospital and Borgess Medical Center, Kalamazoo, who discussed, "Regional Perinatal Care and Health Care Systems"; Rosanne C. Perez-Woods, RN, EdD, School of Nursing, Loyola University Medical Center, Chicago, who discussed "Changing Trends in Perinatal Nursing Practice"; and John M. Beazley, MD, Department of Obstetrics and Gynecology, University of Liverpool, England, who discussed, "Perinatal Health Care Systems."

Continued on next page

HIGHLIGHTS/Continued

Photos of the 27th Annual Michigan Conference on Maternal and Perinatal Health were taken by Pattrick Yockey of East Lansing.

Mark I. Evans, MD, director, Division of Reproductive Genetics, Wayne State University/Hutzel Hospital, discussed “Ethical Dilemmas in Reproductive Technology” during an afternoon of ethical discussions at the 27th Annual Michigan Conference on Maternal and Perinatal Health. Among the ethical dilemmas discussed by Doctor Evans were surrogate mothering, selective terminations and earlier diagnostic techniques.

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School workplace wellness conference worthwhile

By Peg Snarey

Editor's note: The March 1988 issue of *Michigan Medicine* featured an article on "School workplace wellness: moving forward with physician support," which addressed the potential in Michigan for developing comprehensive school health education programs for students and teachers. The article revealed that the creation of such programs is fast becoming a reality due to the Island Conference for School Workplace Wellness, which is now entering its third year. The following article offers a personal account of how one educator from Bridgeport, after attending the conference, was able to deal with her husband's sudden heart attack, and embark upon a healthy lifestyle for herself and her family.

Being selected to attend the Island Conference for Wellness from my school district (Bridgeport) sounded like a great time. With this in mind, I selected classes I thought would be beneficial to myself, my family and then to the district. I selected workshops that would help me help my husband, who had experienced high blood pressure for 14 years. I chose workshops dealing in stress, weight management, fitness, cholesterol reduction, sodium intake reduction, and dealing with life's hurts.

When the time arrived, I couldn't have asked for more. The weather was great, the company stimulating, and the workshops informative. I even won a couple of prizes (a cup, a T-shirt, and a cookbook, "*Cooking Without Your Salt Shaker*") during the raffle. I left the conference, shall we say, "inspired to be healthy." I even quit smoking!

Monday, following my return home, my world exploded before me. My husband suffered a heart attack. The following week was hell; how much damage was done to the heart, was surgery going to be required, was my husband going to be able to coach football? He had just been appointed head varsity football coach at Bridgeport. This was something he had worked for and wanted for 18 years.

> "Following my return home, my world exploded before me. My husband suffered a heart attack. The following week was hell. The workshop on stress came in handy."

I was under *stress*. The workshop on stress came in handy, as I recalled the following advice. "Pause! Evaluate all factors causing stress. Decide what you can and cannot do to solve the problems. Wait!"

After nine days, we were informed that there was damage, surgery was unwarranted at this time, and yes he could coach if he could learn to handle stress. He had to quit smoking and his diet must change. The information on cholesterol and sodium reduction, weight management and exercise I had just learned fell into place. The courses in culinary heart workshop, dealing with life's hurts, and stress management helped me cope and put everything in proper perspective.

These coping mechanisms were applied to every member of my family. All this helped my husband, myself, and a small part of our community. Everyone was concerned. They wanted to know what we were going to do to reduce his chances of a recurrent heart attack. I told them everything I learned from the workshops.

Our lives have changed as a result. We walk nearly every day and watch what we eat. My husband's cholesterol count has come down from 252 to 191. He has lost six pounds although he was never overweight. He feels great! Even his football team is winning, which also eliminates stress.

As for me, I'm losing weight, but most importantly, I know that what I learned at the conference has made a difference in my lifestyle. I am looking forward to this year's conference and working with my fellow employees in promoting wellness.

Thanks. ☐

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INDEX

1 U-M Medical Center receives $8.25 mil .... page 280

2 Macomb cancer program approved .... page 280

3 Spouses show striking similarities in health risks and behaviors .... page 280

4 HealthAccess receives award .... page 286

5 500,000 to die of cancer within 5 years: report .... page 287

6 Consumer awareness campaign on the Pill expanded .... page 288

7 U-M offers specialized pediatric ambulance service .... page 288

U-M Medical Center receives $8.25 million

The Lucille P. Markey Charitable Trust has awarded The University of Michigan an $8.25 million grant for five years of research into the complex way in which nerve cells exchange messages in the brain.

The research will focus on neurotransmitter receptors—proteins that act as gateways between nerve cells—and will be led by co-principal investigators Bernard W. Agranoff, MD, director of the Mental Health Research Institute (MHRI), and Sid Gilman, MD, chairman of the U-M Department of Neurology.

“This is one of the largest research grants ever received by the University. We are very pleased to be the recipients of this exceptionally generous award by the Markey Trust directors,” said U-M Interim President Robben W. Fleming. “The basic research undertaken with this grant may help solve some of the more persistent riddles of how the brain functions.”

Doctor George D. Zuidema, U-M vice provost for medical affairs and professor of surgery at the Medical School, said the grant “will allow a number of our faculty working in the neurosciences to develop some very innovative ideas, and will greatly strengthen our entire research effort in this area.”

Macomb cancer program approved

The Commission on Cancer of the American College of Surgeons has granted three-year approval to the cancer program at Macomb Hospital Center, Warren.

Established by the American College of Surgeons in 1956, the national Hospital Cancer Program encourages participating hospitals to equip and staff themselves to provide the best in the diagnosis and treatment of cancer. Recognizing that cancer is a complex group of diseases, the program promotes consultation among family physicians, surgeons, medical oncologists, diagnostic and therapeutic radiologists, pathologists, and other cancer specialists.

Spouses show striking similarities in health risks and behaviors

It’s been suggested that married couples grow to look alike after years of living together. Whether or not that’s true, a new study by The University of Michigan Fitness Research Center (FRC) indicates that many spouses do act alike, at least in terms of their health behaviors.

FRC researchers Louis Yen and Professor D. W. Edington found significant similarities between husband and wives on demographic characteristics, psychological perceptions, physiological measures, projected health risks and lifestyle habits.

“These correlations suggest that a person’s controlled health risk can be significantly predicted by his or her spouse’s health-related measures,” they report.

Yen and Edington drew a sample of 438 married couples from 5,000 Health Risk Appraisals

Continued on page 286

Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Surindar Singh Bedi, MD
Action, Date Taken: 2 Year Suspension, January 14, 1988
Reason: Negligence/Incompetence, Promotion of unnecessary treatment for personal gain

Name: James Hilton Davis, MD
Action, Date Taken: Revocation, 2/18/88
Reason: Criminal Conviction/Sexual Misconduct

Name: Kiran Gulati, MD
Action, Date Taken: Reprimand, Fine—$500.00, Earn 100 CME—Cat. 1 in addition to 150 CME Mandated for current license renewal, 11/12/87
Reason: Failed to demonstrate compliance with CME required for licensure

Name: Herbert L. Isaac, MD
Action, Date Taken: Reprimand, Fine—$500.00, Earn 100 CME—Cat. 1 in addition to 150 CME Mandated for current license renewal, 11/12/87
Reason: Failed to demonstrate compliance with CME required for licensure

Name: Edith J. Lee, MD
Action, Date Taken: 30 days Suspension, 1 Year Probation & $1,000 Fine, Revocation, January 15, 1988
Reason: Violated Terms of Probation; Federal Registration Revoked

Name: Arthur S. Lightfoot, MD
Action, Date Taken: Summary Suspension, December 17, 1987
Reason: Sexual Misconduct

Name: Gary A. Renard, MD
Action, Date Taken: Reprimand, Fine—$500.00, Earn 100 CME—Cat. 1 in addition to 150 CME Mandated for current license renewal, 10/23/87
Reason: Failed to demonstrate compliance with CME required for licensure

Continued on page 292

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1 For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2 For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3 The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases In more severe cases supplementation with potassium salts may be indicated

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene)

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS**.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity K-DUR should be given to a pregnant woman only if clearly needed

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose

Skin rash has been reported rarely

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval) Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract The clinical significance of these animal studies is yet to be defined However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose) There was no evidence of drug-related tumorigenicity A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment Mutagenicity studies were not conducted

Pregnancy: Teratogenic effects Pregnancy Category B Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers: It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%)

Constipation was the most frequent complaint (2.2%) Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo

OVERDOSAGE

There is no experience in humans with overdosage Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose Risks associated with overdosage should, therefore, be minimal

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination

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Issued 1/87

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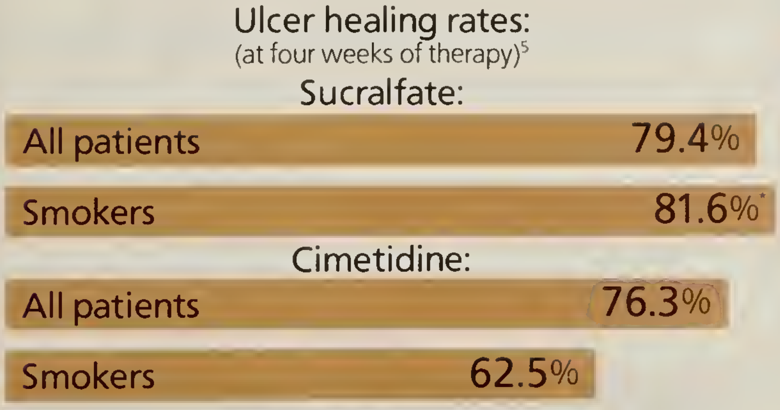

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ARMY RESERVE MEDICAL PROFILE NO.7

Soldier being examined for effects of high-altitude cerebral edema.

ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow,
Massachusetts General Hospital, Boston, Massachusetts.
Captain, U.S. Army Reserve.

EDUCATION Ithaca College, B.A. (Magna Cum Laude); Hamilton College (Pre-med); Harvard Medical School.

RESIDENCY General Surgical Internship. Neurosurgical Residency, Massachusetts General Hospital.

CONTINUING EDUCATION Neurology and Neurosurgery Research Fellowship Training, National Institutes of Health.

OUTSTANDING ACHIEVEMENTS Olsen Memorial Fellowship, National Masonic Medical Research Foundation; Albert Schweitzer Fellowship, International Albert Schweitzer Foundation; Harvard Medical School Cabot Prize for Best Senior Thesis; recently published article, "Who Shall Live and Who Shall Die" in Newsweek Magazine.

"The work I'm doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn't ask for a smoother transition. And that's true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

"Some of the projects the Army is undertaking are on the cutting edge of research. For example, I'm currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

"The quality of medicine and the caliber of people I've been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I'm giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General."

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NEWSFRONTS/Continued

completed by employees of a Michigan corporation and their spouses.

The couples were mainly white (98 percent), aged 30-44 (over 50 percent) and non-college graduates (over 70 percent). The husbands tended to be older and better educated than their wives.

Compared to their wives, a higher number of husbands are currently smoking, drinking more than seven drinks per week, sleeping fewer or more than the recommended seven to eight hours per night, and not wearing a seatbelt. More wives report using mood-altering drugs or medications.

Still, 53 percent of couples match one another's behavior in exercise, 46 percent report the same smoking habits and 66 to 67 percent match in drinking and seatbelt usage. The researchers even found a correlation in the percentage overweight reported by husbands and wives.

A higher percentage of wives (48 percent) reported stronger than average social ties with friends and relatives than did their husbands (39 percent). However, the couples were nearly identical in their perceptions of life satisfaction, physical health and lack of recent personal loss.

"Seven lifestyle-related variables in particular appear to predict health risks in four ways: the husband's responses predict their own and their wives health risks, and the wives' responses also predict their own and their husband's health risks," Yen and Edington report.

"Those variables are smoking, drinking, exercise, seatbelt usage, blood pressure, cholesterol and life satisfaction.

"In sum, this study confirms that the family environment and culture is an important factor affecting a person's health. We have yet to identify the possible mechanism which creates the similarity in health-related measures among the spouse pairs."

HealthAccess receives award

HealthAccess, Northern Michigan Hospitals' (NMH) new medical information and physician referral service, has received an award from one of the most prestigious healthcare marketing competitions. The Academy for Health Services Marketing presented HealthAccess a silver award in the organization's 1987 Academy Award competition.

The award was given to Carol

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The program took a second place in the Academy Awards in a category of more than 500 entries. HealthAccess received the honor because it is a program that draws interest to the hospital through advertising, creates a way to refer people to physicians, offers the personal touch by having a registered nurse answer medical questions, all while providing a positive image of the hospital.

500,000 to die of cancer within 5 years: Report

Nearly 1 million Americans will be diagnosed with cancer this year and more than half will die within five years, according to an American Cancer Society report.

The report also said an estimated 494,000 cancer patients will die this year.

Lung cancer will remain the No. 1 cancer killer in the country, with colon and rectum cancers coming in second and breast cancer third, *Cancer Facts and Figures 1988* said.

Uterine cancer will be fourth,

Continued on next page

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"HERPECIN-L appears to actually **prevent** the blisters . . . used **soon enough."** DDS, MN

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"Used at **prodromal symptoms** . . . blisters **never formed** . . . remarkable." DH, MA

"(In clinical trials) . . . **response** was **dramatic.** **HERPECIN-L** . . proven **far superior."** DDS, PA

"All patients claimed **shorter duration** . . . at **prodromal symptoms** . . . HERPECIN-L **averted** the attacks." MD, AK

OTC. *See P.D.R.* for information. For samples to make your own clinical evaluation, write: CAMPBELL LABORATORIES, INC., P.O. BOX 812-MD, FDR STATION, NEW YORK, N.Y. 10150

In Michigan, HERPECIN-L is available at all *Perry, Revco, RiteAid, SupeRx, Walgreens* and other select pharmacies.

NEWSFRONTS/Continued

followed by ovarian, oral, prostate, bladder, skin and pancreatic cancers, the report said. Leukemia was considered the least frequent cancer killer.

The report, released annually by the American Cancer Society, projected that 985,000 new cases of cancer will be diagnosed in the country this year.

The highest number — 97,500 — is expected in California. New York comes in second, with 76,500 cases, and Florida third, with 63,800 cases. In Michigan, the cancer society estimates there will be 36,800 new cases. It broke down the figures as follows: Lung cancer—5,200 cases; breast cancer—5,400 cases; colon and rectum cancer—5,200 cases; prostate cancer—36,000 cases, and uterus cancer—1,700 cases.

The society said an estimated 18,500 Michigan residents will die from cancer this year. Michigan has a cancer death rate of 222 persons per 100,000 persons.

Of the new cancer cases this year, the society said more than 500,000 will involve skin cancer. It said the disease can be avoided by staying away from direct sunlight.

An estimated 152,000 new cases of lung cancer are expected to be diagnosed in 1988, killing about 139,000 people this year, the report said.

Smoking is responsible for about 83 percent of the lung cancer cases in the country, the society said.

The organization predicted there would be 147,000 new cases of colon and rectum cancer, leading to an estimated 61,500 deaths this year.

Consumer awareness campaign on the Pill expanded

Sponsors of the first nationwide consumer awareness campaign for oral contraceptives, launched last fall, have unveiled a new print advertisement designed to strengthen the messages carried in the original campaign. Sponsored by the Association of Reproductive Health Professionals (ARHP) and funded through an educational grant from Ortho Pharmaceutical Corporation, the new print ad emphasizes the reduction in oral contraceptive hormone levels since the Pill was first introduced in the early 1960's.

According to Doctor Michael Burnhill, president of the ARHP, this new component logically extends the original campaign and supports growing physician advocacy of lower-dose Pills.

"Reproductive experts have stressed for several years that oral contraceptives containing 50 mcg estrogen or less are preferable," says Burnhill. "They believe that higher-dose products are unnecessary since they offer no unique clinical advantage."

The new print ad, designed by DDB Needham Worldwide, will appear in numerous publications including *USA Today*, *Time*, *Newsweek*, *Cosmopolitan*, *People*, and *Working Woman*.

U-M offers specialized pediatric ambulance service

A specially equipped and staffed ambulance is now available to transport critically ill children to and from The University of Michigan Medical Center.

The Pediatric Ground Transport Service is the latest addition to the Medical Center's Pediatric Critical Care Transporting System. The system also includes 24-hour helicopter and airplane ambulance service.

Candidates for ground transport are non-trauma patients under age 18 who are not so critically ill that they need immediate air transport, but still require skilled care during transport. Many illnesses can place a patient in this category, but meningitis, pneumonia, seizures and heart problems are among the more common conditions requiring the service.

For inbound transports, the Ground Transport Service is staffed by a physician from the the U-M Department of Pediatrics and Communicable Diseases, a specially trained nurse from the Survival Flight helicopter team, a driver who is trained as an emergency medical technician, and, if required, a respiratory therapist. ☐

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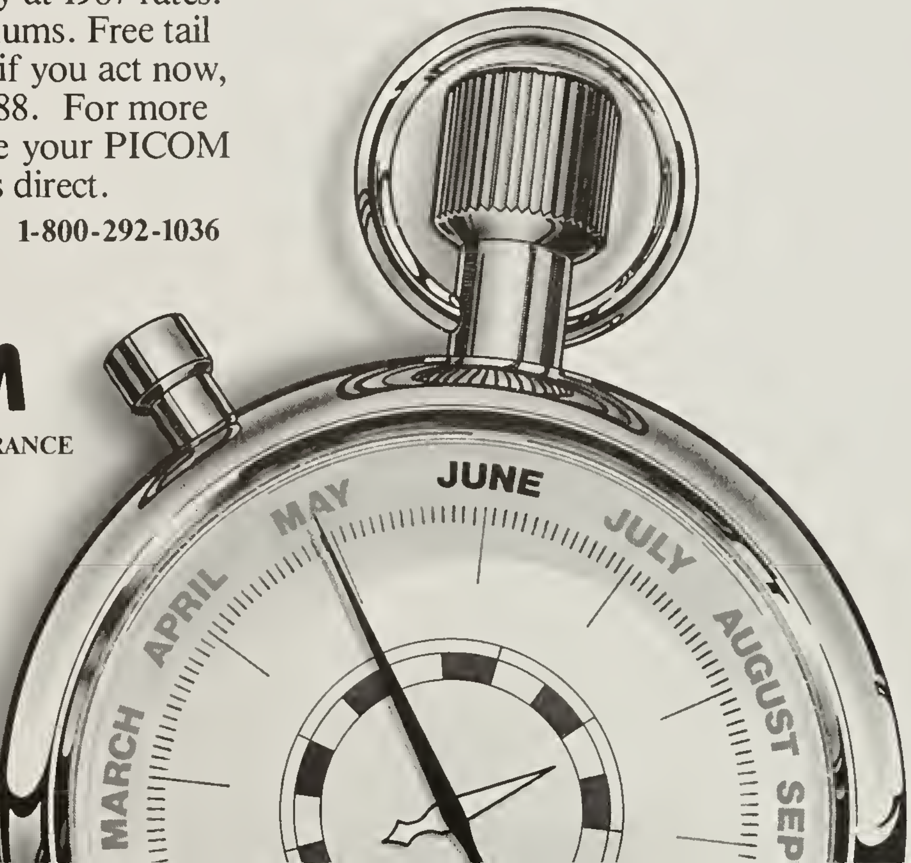


PHYSICIANS IN THE NEWS

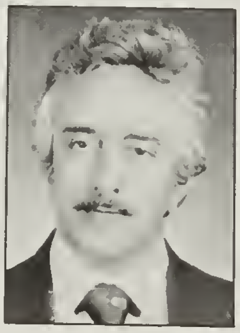
J. Jay Post, MD, an Allendale family practitioner, has been named a first prize winner of a national competition which asked doctors across the country to depict the meaning of quality of life through photography. The Capoten® Quality of Life Photo Contest was sponsored by Squibb Corporation. Doctor Post's award-winning photo (above) captures an older gentleman engrossed in the task at hand. According to Doctor Post, this 91-year-old just started his second career as an archivist. He believes that certain attitudes toward life, such as optimism, enthusiasm, curiosity and a sense of humor, will help to make each new day a rewarding experience.

Alan Morgan, MD, Flint, medical director of emergency medicine at St. Joseph Hospital, recently became certified as a diplomate by the American Board of Emergency Medicine. . . . William Beaumont Hospital, Troy, announced recently the appointments of **Kirit Vora, MD**, chairman, Department of Urology, **Robert Saieg, MD**, vice chief, Gynecologic Service and **Karl Kolbe, MD**, chairman, Internal Medicine Department, all of Troy. . . . **Archie W. Bedell, MD, PhD**, Mt. Clemens, has been named chairman of a new Family Practice Department at Henry Ford Hospital and will be establishing a family practice residency program at the hospital. . . . **Margaret Z. Jones, MD**, East Lansing, professor of pathology at Michigan State University, has been named recipient of the Michigan Association of Governing Boards (MAGB) distinguished faculty award. . . . **Alan Sugar, MD**, Ann Arbor, of the Kellogg Eye Center at the University of Michigan, has been appointed as a consultant to the Ophthalmic Device Advisory Panel of the Food and Drug Administration (FDA) in Washington, D.C. . . . **Phil VanderWoude, MD**, Greenville, recently was appointed to the board of trustees at the United Memorial Hospital in Greenville. . . . **Tom Johnson, MD**, East Lansing, former dean of the University of North Dakota School of Medicine and executive director of the University's medical center, has joined the administrative team of the College of Human Medicine as associate dean at Michigan State University. . . . **David Fromm, MD**, Grosse Pointe Farms, has been

Bedell

Jones

Francis



Aboulafia

Peebles-Meyers

Swan

Continued on page 294

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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BOARD OF MEDICINE ACTIONS/Continued

Name: Andre Louis Rowlett, MD
Action, Date Taken: Reprimand, Fine—$500.00, Earn 62 CME—Cat. 1 in addition to 150 CME Mandated for current license renewal, 10/23/87
Reason: Failed to demonstrate compliance with CME required for licensure

Name: Luisa Sarroza, MD
Action, Date Taken: Reprimand, Fine—$500.00, Earn 100 CME—Cat. 1 in addition to 150 CME Mandated for current license renewal, 10/28/87
Reason: Failed to demonstrate compliance with CME required for licensure

Name: Robert J. Sillery, MD
Action, Date Taken: Revocation, January 19, 1988
Reason: Criminal Conviction/Drug Diversion

Name: Fred G. Swartz, Jr., MD
Action, Date Taken: Reprimand, Fine—$500.00, Earn 100 CME—Cat. 1 in addition to 150 CME Mandated for current license renewal, 11/12/87
Reason: Failed to demonstrate compliance with CME required for licensure

Name: Myron A. Tazelaar, MD
Action, Date Taken: Reprimand, Fine—$500.00, Earn 100 CME—Cat. 1 in addition to 150 CME Mandated for current license renewal, 10/23/87
Reason: Failed to demonstrate compliance with CME required for licensure

Name: David A. Vila, MD
Action, Date Taken: 2 Year Suspension
Reason: Drug Diversion

"I *SAID* you can stick your tongue back in, Raymond."

IN MY OPINION/Continued

Medicine stronger and more effective.

Physicians would be willing to pay a higher fee knowing that all of their money would go directly to the Board of Medicine for administration and Board activities.

This one act would answer our sharpest critics and would greatly improve the functions and services of the Board in the best interests of the public, Michigan hospitals and the patients. All Michigan physicians could endorse and support such a fee increase if all of that money was going directly to the Board, rather than to the general fund or to the Department of Licensing and Regulation.

House Bill 4820 is perhaps a start in the right direction. But rather than letting the Board of Medicine fix the fees, the Bill would again have the legislature set the fees. House Bill 4820 will prohibit the use of fee revenue for any other purpose except to offset Department of Licensing and Regulation costs, but still does not allow the money to go directly and specifically in its entirety to the Michigan Board of Medicine.

Although House Bill 4820 would be an improvement, and does allow the Department of Licensing and Regulation rather than the legislature to determine how the fees are spent, it still does not give the Board the right to spend all the collected funds exclusively for its own expenses. Nor does it establish proper and necessary fee schedules to sufficiently fund the Board of Medicine. ☐

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PHYSICIANS IN THE NEWS/
Continued

named chief of surgery for Harper-Grace Hospitals. Doctor Fromm has also been appointed chairman of the department of surgery at the Wayne State University School of Medicine and physician-in-chief of surgery at the Detroit Medical Center. . . . **Elie D. Aboulafia, MD**, Farmington Hills, was elected second president-elect at the annual meeting in New Orleans recently of the US Section of the International College of Surgeons. . . . **Marjorie Peebles-Meyers, MD**, Dearborn, has been reappointed to the Judicial Tenure Commission by Governor James J. Blanchard for a term expiring December 31, 1990. . . . **Warren B. Greenspan, MD**, Adrian, has recently been appointed new director of anesthesiology at Emma L. Bixby Medical Center. The New York native arrived at Bixby earlier this month, bringing with him some medical techniques that are widely used in the East, but are fairly new to the Midwest. . . . Cardiologist **John E. Francis, MD**, Kalamazoo, has assumed the post of chief-of-staff for Borgess Medical Center succeeding Lee Underwood, MD, urologist. Like Doctor Underwood, Francis will serve in the elective capacity for a two-year term. . . . **Robert M. O'Neal, MD**, Ann Arbor, a plastic surgeon and clinical professor of plastic surgery at the University of Michigan School of Medicine, has been elected chief of the medical staff at Catherine McAuley Health Center in Superior Township. . . . **Nancy Newlin, MD**, Tecumseh, has been appointed chief of staff at Herrick Memorial Hospital. Doctor Newlin, a radiologist, has been at Herrick for 11 years. She is responsible for the hospital's medical imaging department. . . . **Lionel Swan, MD**, Detroit, attended the Detroit Urban League's ninth annual Salute to Distinguished Warriors dinner where he was awarded a distinguished warrior award for improving black medical care. ☐

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CORRECTION

In the March 1988 issue of *Michigan Medicine*, James T. Sgouris, MD, in his article, "MDPH recommendations for physician office laboratories," was incorrectly identified as being a DO.

"It's no big deal . . . Just a bad case of spring fever."

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LETTERS/Continued

A physician's testimony in court is considered by the Board to be part of the practice of medicine.

Norman Bolton, MD
Detroit

MSMSA update

As the current American Medical Association Education and Research Foundation National Chairman, I will be present at the opening session of the National House of Delegates this June in Chicago and seated next to our National President, Mrs. Betty Szewczyk. During the opening session remarks, Mrs. Szewczyk will make a formal presentation to the House of the AMA-A's check representing monies raised throughout the year.

As a past state MSMSA president, and current MSMSA board member and committee member of MSMS, I knew you would wish to be informed of my presence during this national ceremony.

I am pleased to tell you that the AMA Auxiliary President Elect, Mrs. Mary Strauss, has asked me to serve another year as the AMA-ERF chairman. My position begins at the close of the 1988 AMA-A Annual Session. As stated in our MSMSA Bylaws, my membership on the AMA-A Board automatically makes me an ex-officio member of the 1988-89 MSMSA Board.

It has been an honor to serve the National AMA Auxiliary and I am proud to represent Michigan another year. If I can be of any service to MSMS or MSMSA during the AMA House of Delegates meeting in June, or at any time during the 1988-89 year, please don't hesitate to let me know.

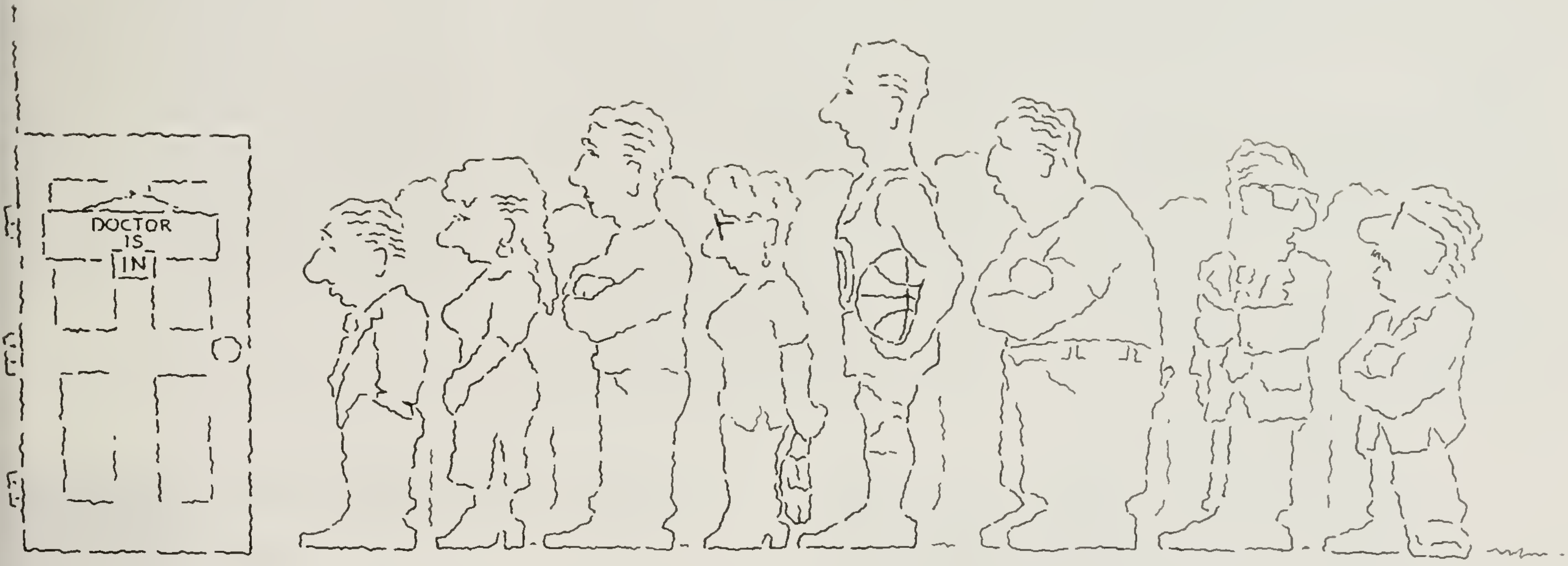
Cathie L. Martin
Past State President MSMSA

30 Reasons to Love Your Lungs

Reason #12: Respiratory distress syndrome (RDS), an infant lung disease, accounts for 20% of the total infant mortality in the U.S. each year.

American ‡ Lung Association of Michigan

"He looks like you, Harold."



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...helping doctors get down to business.

Michigan Medicine wins another award

Michigan Medicine recently won a $500 first prize in the 13th annual medical journalism competition by Sandoz Pharmaceuticals. It tied for first place with *New Jersey Medicine*, a scientific journal.

This year marked the first time Sandoz awarded two first prizes, according to Craig D. Burrell, Sandoz vice president:

"For the first time, the judges were deadlocked in the state association category. It simply was impossible to compare the all-news format of *Michigan Medicine* with the scientific journal format of *New Jersey Medicine*.

"So, the judges resolved it by giving first prizes to both. There also are many other excellent publications in your category, so the decision indeed was difficult, and a compliment to you and your associates."

Sandoz awards are given for "outstanding appearance and editorial qualities" in four categories — state medical journals, county and city medical publications, state pharmaceutical publications, and journals and other nonemployee publications published by hospitals and medical groups, according to Burrell. In the state medical journals category, areas which are judged include: the cover, contents page, title typography, text, captions, photography, makeup, and style. *Michigan Medicine* received perfect scores in six of the eight categories. ☐

Justice Is Blind.
I Can See Her
Point Of View.

Here's one for the books. Seems this gentleman graduated from the Wharton School of Business with highest honors, near the top of his class. But, because he was legally blind, all the employers who interviewed him couldn't see how valuable he was. He couldn't get a job, so he decided to go back to college. Graduated three years later at the top of his class at Harvard Law School. And now he's very successful in a profession where the people who make all the decisions "hear" arguments and render a verdict accordingly.

Now, the individuals who thought this fellow wasn't employable in the first place would probably say "Well, he's an exceptional case." And they'd be wrong again. Because—according to a recent Louis Harris Poll—people with disabilities tend to work harder, take their jobs more seriously and perform as well or more productively than people who *aren't* disabled.

If you'd like more information on acquiring these assets for your company, please call or write us, and we'll put you in touch with some exceptional people.

Reserve judgement until you see how well they do. And when the verdict is in, let us know. We know where you can find some more.

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NCUA

DEATHS

Carlton F. Brown, MD
Royal Oak

Doctor Brown, a gastroenterologist, died March 22 at the age of 83. He was a member of the staff of Grace Hospital. Before he began his medical career, he was, at age 18, a teacher of English in a country school in Ironwood. He was a graduate of Northern State College and received his medical degree from Wayne State University in 1935. He was a member of the Wayne County Medical Society.

John B. Bryan, MD
Royal Oak

Doctor Bryan, an internal medicine specialist, died March 24 at the age of 66. He was a 1946 graduate of Duke University and was affiliated with Henry Ford Hospital. He was a member of the American Medical Association, Wayne County Medical Society, American College of Physicians, American Diabetes Association, and was past-president of the Oakland County Medical Society. He also was active on the MSMS Committee on Impaired Physicians and Medical Economics.

Arthur H. Cameron, MD
Detroit

Doctor Cameron, a general practitioner in the Detroit area for over 50 years, died January 24, 1988. Doctor Cameron received his medical degree from McGill University School of Medicine. He did his internship and residency at Royal Victoria Hospital, Montreal. In 1923, Doctor Cameron started his practice in Wyandotte and remained there until his retirement. He was a member of the American Medical Association and the Wayne County Medical Society.

Bernice Izner, MD
Southfield

Doctor Izner, a child psychiatrist, died February 3 at the age of 81. A 1928 graduate of the University of Wisconsin, she received her medical degree in 1932 at the Stritch School of Medicine, Loyola University, in Illinois. She was a member of the Michigan Society of Psychiatry, Wayne County Medical Society, and the American Psychiatric Association.

Anna Ester Johnson, MD
Monroe

Doctor Johnson, a general practitioner, died December 31 at the age of 87. She was a graduate of the University of Michigan Medical School in 1936. She served on staff at Mercy and Monroe Hospitals. She was past-president and member of the American Medical Women's Association, and a member of the Monroe County Medical Society.

Francis L. Markey, MD
Saginaw

Doctor Markey, a general practitioner, died March 11 at the age of 69. He graduated from Marquette Medical School in 1944. He was a member of the American Medical Association and the Saginaw County Medical Society, and was a World War II Navy Veteran.

William E. Nesbitt, MD
Alpena

Doctor Nesbitt, a general practitioner, died December 10 at the age of 85. He was graduated from the University of Michigan in 1927 and was affiliated with the Alpena General Hospital. He had been a member of MSMS since 1929. He was a member of the American Academy of Family Practice and the Alcon/Presque'Isle County Medical Society.

Leon S. Obushkevich, MD
Detroit

Doctor Obushevich, a general practitioner in the Detroit area for 34 years, died November 14, 1987 at the age of 74. He received his medical degree from the University of Louvain, Belgium. He interned at St. Peter Hospital, Louvain, and served his residency at City Hospital, Doebeln, Germany. Doctor Obushkevich came to the United States in 1949. He completed an internship at Deaconess Hospital and a residency at Saratoga General Hospital. He was a member of the American Medical Association and the Wayne County Medical Society.

James N.P. Struthers, MD
Saline

Doctor Struthers, a child psychiatrist, died March 9 at the age

Continued on page 303

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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), and (4) patients who have demonstrated hypersensitivity to the drug.

WARNINGS

1. **Cardiac Conduction.** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. **Congestive Heart Failure.** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.*
3. **Hypotension.** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. **Acute Hepatic Injury.** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGDT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Dermatological events (see ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

Drug Interaction. *Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.)*

Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

Beta-blockers: *Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities.*

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine: *A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a one-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.*

Digitalis: *Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)*

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/ postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree—see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, depression, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGDT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, CPK elevation, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 6/87*

See complete Professional Use Information before prescribing.

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DEATHS/Continued

of 87. He graduated from the University of Toronto in 1926 and served his internship in Detroit where he practiced general medicine for eight years. He joined the Michigan Department of Mental Health and served on the staff of Kalamazoo State Hospital. In 1945 he became director of the Huron Valley Center and designed the 80-bed York Woods facility in 1962.

Seymour K. Wilhelm, MD
Detroit

Doctor Wilhelm died March 3 at the age of 69. He was chairman of the electrocardiographic services of Mt. Carmel Mercy Hospital since 1947. He was an adjunct clinical associate professor at Mercy College and a clinical assistant professor at Wayne State University. He was past president of the Michigan Heart Association and The Detroit Heart Club. He was a fellow of the American College of Cardiology, American College of Angiology, Royal Society of Health and New York Academy of Arts and Science.

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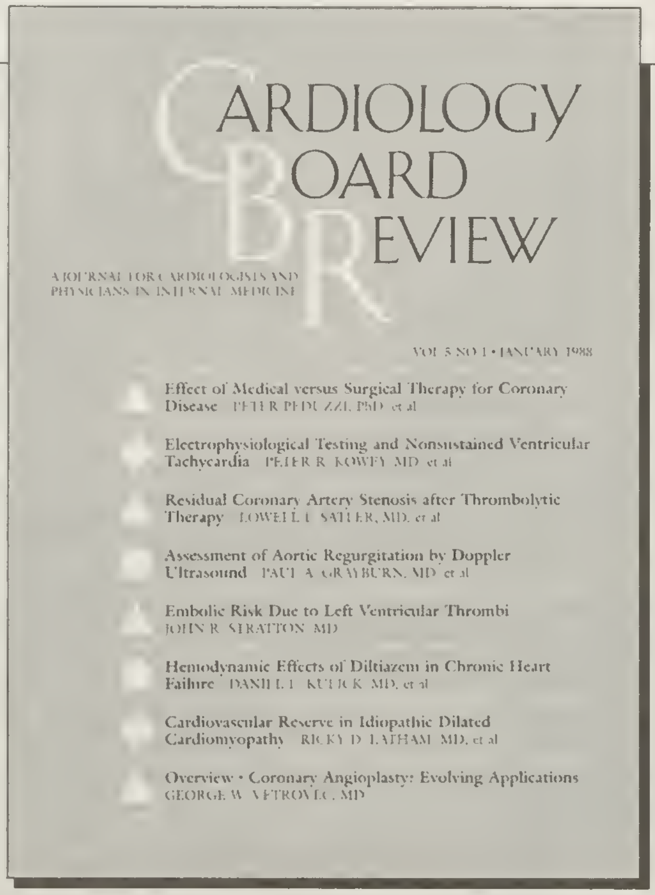

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Continued on page 310

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The Annual Meeting of MOMA will be June 2-3 at Shanty Creek Resort near Bellaire. The program will offer up to 7 hours of Category 1 credit as well as conviviality.

For information on membership and/or meeting
Contact: David Jacknow, MD
25 Cabot Place, Bloomfield Hills 48013
313-642-3970

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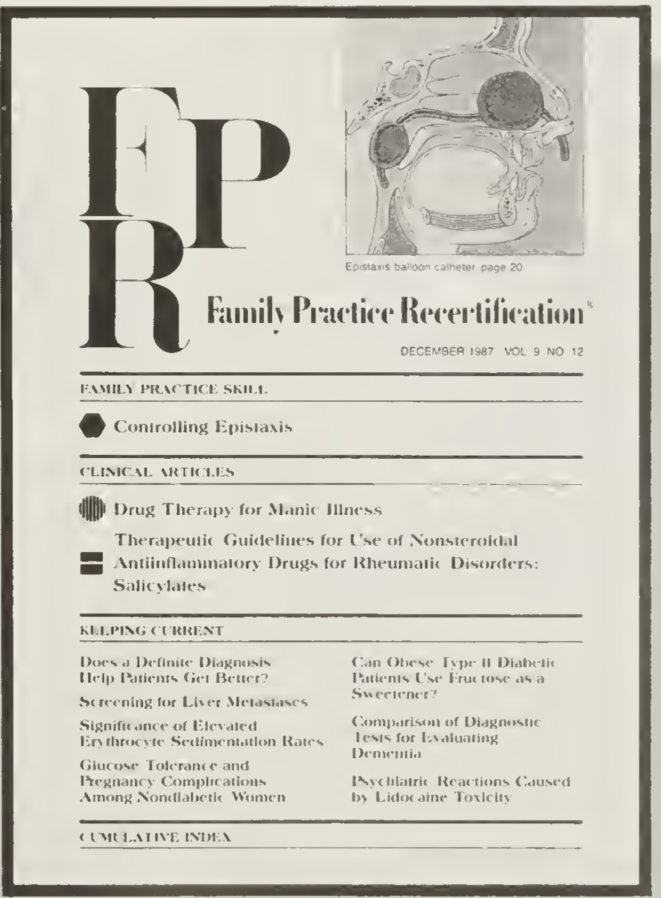

FPR
Epistaxis balloon catheter page 20
Family Practice Recertification
DECEMBER 1987 VOL 9 NO 12

FAMILY PRACTICE SKILL
Controlling Epistaxis

CLINICAL ARTICLES
Drug Therapy for Manic Illness
Therapeutic Guidelines for Use of Nonsteroidal Antiinflammatory Drugs for Rheumatic Disorders: Salicylates

KEEPING CURRENT
Does a Definite Diagnosis Help Patients Get Better?
Screening for Liver Metastases
Significance of Elevated Erythrocyte Sedimentation Rates
Glucose Tolerance and Pregnancy Complications Among Nondiabetic Women
Can Obese Type II Diabetic Patients Use Fructose as a Sweetener?
Comparison of Diagnostic Tests for Evaluating Dementia
Psychiatric Reactions Caused by Lidocaine Toxicity

CUMULATIVE INDEX

PRACTICAL ▪ CLINICAL ▪ EDUCATIONAL ▪ CURRENT

Family Practice Recertification Greenwich Office Park 3, Greenwich, CT 06831 / (203) 629-3550

NEW MEMBERS/Continued

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Albion 49224

Sid M. Shah, MD — EM
2825 Staten Ave. #22
Lansing 48910

Dennis N. Shelle, MD — IM/PD
402 E. Chicago Blvd.
Tecumseh 49286

Dean G. Sienko, MD — PH/PM
11380 Wood Road
DeWitt 48820

Paul A. Sieving, MD — OPH
1000 Wall St.
Ann Arbor 48105

Gregory L. Skuta, MD — OPH
1000 Wall St.
Ann Arbor 48105

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31975 Eastlady Drive
Birmingham 48010

Neal A. Smith, MD — FP
450 Hickory Lane
Pontiac 48054

Cynthia Ann Smith, MD — PD
525 S. Woodward
Royal Oak 48067

Rudy W. Stefancik, MD — PTH
175 College St.
Battle Creek 49017

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Henry Ford Hospital IM/DEPT
Detroit 48202

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East Jordan 49727

Richard Trudeau, MD — GP
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Marcellus 49067

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Zeeland 49464

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22255 Greenfield
Southfield 48075

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1 South Fifth St.
Niles 49120

Laurie G. Winkelman, MD — IM
1062 Island Drive Ct. #106
Ann Arbor 48105

Honor M. Wolfe, MD — OBG
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category 1 credit toward meeting the requirements of Michigan law. Sponsors of Category 1 programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category 1 credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

May

16-17, Recent Trends in the Electrophysiologic Assessment of Auditory Function: Neuro-Otologic and Intraoperative Applications; Pediatric and Neonatal Applications. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Otolaryngology. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. Approved for: 14 hours Category 1 Credit.

19-20, Clinical Ischemic Syndromes: Mechanisms and Consequences of Tissue Injury. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Surgery and the Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education. Contact: Debbie DeSmyther, Towsley Center for Continuing Medical Education, Box 0201, University of Michigan Medical School, Ann Arbor, 48109 (313)763-1400. Approved for: 14 hours Category 1 Credit.

19-20, 33rd Annual Clinic Days. Location: Kresge Auditorium of Harper Hospital, 3990 John R, Detroit. Sponsor: Wayne State University School of Medicine. Contact: Wayne State University School of Medicine, Division of Continuing Medical Education, 4-H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180. Approved for: 10 hours Category 1 Credit.

20-21, Current Concepts in Glaucoma: 60th Annual Ophthalmology Spring Conference in conjunction with the 10th Annual Midwest Glaucoma Symposium. Location: W. K. Kellogg Eye Center, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Ophthalmology. Contact: Arlene Bradford, Towsley Center for Continuing Medical Education, University of Michigan, Ann Arbor 48910 (313)763-1400. Approved for: 13 hours Category 1 Credit.

25, Client Services through Clinical Excellence. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. Sponsor: Southwestern Michigan Area Health Education Center, 4th Floor Stryker, 1521 Gull Road, Kalamazoo. Contact: Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 1521 Gull Road, 4th Floor Stryker, Kalamazoo 49001 (616)341-6360. Approved for: 6 hours Category I Credit.

June

2-3, Current Topics in Blood Banking: 15th Annual Symposium. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: The University of Michigan Medical School, Department of Pathology. Contact: Gayle Fox, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 12 hours Category 1 Credit.

2-3, 14th Annual Kalamazoo Symposium for Michigan Neonatologists and Neonatal/Perinatal Medicine Fellows. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. Sponsor: Neonatology Service of the Pediatric Section—Bronson Mead Johnson Laboratories. Contact: John Hartline, MD, Neonatology Service of the Pediatric Section, Bronson Methodist Hospital, 252 East Lovell Street, Kalamazoo 49007 (616)341-6469. Approved for: 7.25 hours Category 1 Credit.

2-3, Annual Meeting Michigan Occupational Medical Association. Location: Shanty Creek, Bellaire. Sponsor: Michigan Occupational Medical Association. Contact: David Jacknow, MD, 25 Cabot Place, Bloomfield Hills 48013 (313)642-3970. Approved for: 7 hours Category 1 Credit.

3, Seventh Annual Cleft Palate Symposium. Location: Waterfront Inn, Traverse City. Sponsor: Michigan Cleft Palate Association, Center for Human Services, Western Michigan University. Contact: Janet Wilson, Center for Human Services, Western Michigan University, Kalamazoo 49008 (616)383-4941. Approved for: 5 hours Category 1 Credit.

4, AIDS: A First Responder's Approach. Location: Michigan Inn, 16400 J.L. Hudson Drive, Southfield. Sponsor: The University of Michigan Medical School, Office of Continuing Medical Education, Towsley Center, Ann Arbor. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 7 hours Category 1 Credit.

9, The 6th Annual Clinical Laboratory Computer Symposium. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Pathology. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, The Univesity of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 15 hours Category 1 Credit.

11, Controversies and Medical Management of Post-Menopausal Years. Location: Michigan Inn, Southfield. Sponsor: University of Michigan Medical School, Department of Obstetrics and Gynecology. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 4 hours Category 1 Credit.

19-24, 24th Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Shanty Creek-Schuss Mountain, Bellaire. Sponsor: The University of Michigan Medical School, Department of Family Practice. Contact: Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 20 hours Category 1 Credit.

21, Preventive Oncology. Location: Clarion Conference Center, 6810 S. Cedar Street, Lansing. Sponsor: Ingham County Medical Society and MSMS Committee for Continu-

Continued on next page

CATEGORY 1 COURSES/ Continued

ing Medical Education. **Contact:** Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)332-2320. **Approved for:** 6 hours Category 1 Credit.

July

8-11, Fourteenth Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Betty Phillips, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 11 hours Category 1 Credit.

10-14, Cross Sectional Radiology: MRI, Body CT and Ultrasound. **Location:** Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Henry Ford Hospital, Continuing Medical Education. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3072. **Approved for:** 14 hours Category I Credit.

21-24, Fifteenth Michigan Emergency Medicine Assembly: EMS Concepts 88 and Base Station Symposium. **Location:** Hilton Shanty Creek, Bellaire. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians. **Contact:** Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. **Approved for:** 22 hours Category I Credit.

21-24, Occular Surgery Update: Newest Techniques, Complications and Management of Ocular Tumors. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Contact:** Christine Jourdain, 412 Eastland Professional Bldg., Harper Woods 48225 (313)839-0311. **Approved for:** 8 hours Category I Credit.

24-27, 2nd Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 13 hours Category I Credit.

25, 42nd Annual Scientific Assembly. **Location:** Grand Traverse Resort, Acme. **Sponsor:** Michigan Academy of Family Physicians. **Contact:** Julie L. Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151. **Approved for:** 25.5 hours Category I Credit.

28-29, Coller Penberthy Thirlby Medical Conference. **Location:** Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Munson Medical Center. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City 48684-2386 (616)922-9546. **Approved for:** 13 hours Category 1 Credit.

August

1-6, Pediatric Board Review. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** University of Michigan Medical School, Association of Pediatric Program Directors. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 53 hours Category I Credit.

7-10, Internal Medicine Update. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

13-14, Endocrinology and Diabetes Update. **Location:** Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** University of Michigan Medical School, Division of Endocrinology and Metabolism, Department of Internal Medicine. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 7 hours Category 1 Credit.

19-22, Cardiology Update. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 10 hours Category I Credit.

September

15-16, Neonatal Emergencies. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** University of Michigan Medical School, Department of Pediatrics and Communicable Diseases, Section of Newborn Services and Pediatric Pulmonary Medicine. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 14 hours Category 1 Credit.

15-17, 11th Annual Seminar in Diagnostic Ultrasound. **Location:** Towsley Ceneter for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 15 hours Category 1 Credit.

19-20, Update on Pulmonary and Critical Care Medicine. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 14 hours Category 1 Credit.

22-24, 19th Annual International Symposim on Implant Surgery for the Hand, Upper Extremity and Foot. **Location:** Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** Michigan State University College of Human Medicine, The Intrernational Federation of Societies for Surgery of the Hand, The Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, 1900 Wealthy, S.E., Suite 290, Grand Rapids 49506 (616)774-0440. **Approved for:** 18 hours Category I Credit.

MEETINGS

MICHIGAN STATE MEDICAL SOCIETY
1866

MSMS MEETINGS

July

14-17, MSMS Board of Directors Midsummer Meeting, Shanty Creek, Bellaire, contact: William Madigan (517)337-1351.

September

14, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

October

19, 1988 Public Affairs Leadership Conference, Hilton Inn, Lansing, contact: Mary Anne Ford (517)337-1351.

November

8-10, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent (517)337-1351.

16, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETINGS

June

26-30, AMA Annual Meeting, Chicago Hilton and Towers, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4392 (312) 645-4344.

October

5-6, AMA Seventh Annual Science Reporters Conference, Westin St. Francis Hotel, San Francisco, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4344.

December

4-7, AMA Interim Meeting, Dallas, TX, contact: AMA, 535 North Dearborn St., Chicago 60610 (312) 645-4344.

MICHIGAN SPECIALTY SOCIETY MEETINGS

June

2-3, Michigan Occupational Medicine Association Annual Meeting, Shanty Creek, contact: Richard Rood, MD, Chrysler Corporation, 29232 Gloede, Warren 48093 (313) 977-5001.

17-19, Annual Meeting—Michigan Association of Neurological Surgeons, Grand Traverse Resort, Traverse City, contact: William F. Chandler, MD, 1500 E. Medical Center Drive, Ann Arbor 48109 (313)936-5020.

July

21, Fifteenth Michigan Emergency Medicine Assembly—EMS Concepts 88 and Base Station Symposium, Michigan Chapter of the American College of Emergency Physicians, Hilton Shanty Creek, Bellaire, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500.

22-24, Michigan Society of Medical Assistants Summer Seminar, Michigan Society of Medical Assistants, Holiday Inn, Dearborn, contact: Caroline Kimmel, MSMA, P.O. Box 950, East Lansing 48826-0950 (517)337-1351.

25, 42nd Annual Scientific Assembly, Michigan Academy of Family Physicians, Grand Traverse Resort, Acme, contact: Julie L. Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151.

August

19-20, Michigan Society of Thoracic Surgeons Annual Scientific Meeting, Grand Hotel, Mackinac Island, contact: Luis A. Tomatis, MD, President, 21 Michigan Street, N.E., Suite 550, Grand Rapids 49503 (616)459-6577.

October

2, Michigan Chapter, American Academy of Pediatrics Annual Scientific Meeting, Grand Traverse Resort and Conference Center, Traverse City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018 (313)553-3646.

9, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St.

Continued on next page

Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500.

NATIONAL SPECIALTY SOCIETIES

June

3-7, American Association of Clinical Urologists Annual Meeting, Sheraton/Marriott, Boston, MA, contact: American Association of Clinical Urologists, 21510 S. Main Street, Carson, CA 90745 (213) 549-3470.

9-12, 17th Annual Scientific Assembly, American College of Emergency Physicians, Mission Hills Resort Hotel, Rancho Mirage, CA, contact: CAL/ACEP, 505 N. Supulveda Blvd., #12-14, Manhattan Beach, CA 90266 (213)374-4039.

20-23, American Orthopaedic Association Annual Scientific Meeting, The Homestead, Hot Springs, VA, contact: American Orthopaedic Association, 222 S. Prospect Avenue, Park Ridge, IL 60068 (312)823-7186.

September

14-17, American Group Practice Association Annual Meeting, Hotel Intercontinental, San Diego, CA, contact: American Group Practice Association, 1422 Duke Street, Alexandria, VA 22314 (703)838-0033.

23-24, American Academy of Facial Plastic and Reconstructive Surgery Annual Meeting, Washington, DC, contact: American Academy of Facial Plastic and Reconstructive Surgery, 1101 Vermont Avenue, N.W., Suite 404, Washington, DC 20005 (202)842-4500.

26-29, American College of Emergency Physicians Scientific Meeting, New Orleans Convention Center, New Orleans, LA, contact: American College of Emergency Physicians, P.O. Box 619911, Dallas, TX 75261-9911 (214)550-0911.

October

1-6, American Academy of Family Physicians Annual and Scientific Meetings, New Orleans Marriott, New Orleans, LA, contact: American Academy of Family Physicians, 1740 W 92nd Street, Kansas City, MO 64114 (816)333-9700.

3-7, American College of Chest Physicians Scientific Meeting, Anaheim Hilton, Anaheim, CA, contact: American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068 (312)698-2200.

8-12, American Academy of Ophthalmology Annual Scientific Meeting, Las Vegas, NV, contact: American Academy of Ophthalmology, P.O. Box 7424, 655 Beach, San Francisco, CA 94120 (415)561-8500.

8-12, American Society of Anesthesiologists Annual Meeting, San Francisco Hilton, San Francisco, CA, contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068 (312) 825-5586.

17-19, American College of Gastroenterology Annual Meeting, Hilton, New York, NY, contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944 (617)927-8330.

23-28, American College of Surgeons Annual Meeting, Hilton, Chicago, IL, contact: American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611 (312)664-4050.

26-30, American Academy of Child and Adolescent Psychiatry Annual Meeting, Westin Hotel, Seattle, WA, contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, N.E., Washington, DC 20016 (202)966-7300.

30-11/4, American Academy of Physical Medicine and Rehabilitation Annual Scientific Meeting, Convention Center, Seattle, WA, contact: American Academy of Physical Medicine and Rehabilitation, 122 S. Michigan Avenue, Suite 1300, Chicago, IL 60603 (312)922-9366.

31-11/5, American Academy of Pediatrics Annual Meeting, San Francisco, CA, contact: American Academy of Pediatrics, 141 Northwest Point Road, P.O. Box 927, Elk Grove Village, IL 60007 (312)288-5005.

November

12-16, American College of Allergists Annual Scientific Meeting, Westin Century Plaza, Los Angeles, CA, contact: American College of Allergists, 800 E. Northwest Highway, Suite 101, Mt. Prospect, IL 60056 (312)255-0380.

December

3-8, American Academy of Dermatology Annual Scientific Meeting, Washington, DC, contact: American Academy of Dermatology, 1567 Maple Avenue, P.O. Box 3116, Evanston, IL 60204-3116 (312)869-3954.

H.M.S.S.

The AMA
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The rate for classified advertising in *Michigan Medicine* is 80 cents per word, with a minimum charge of $40.00. Copy for classified advertisements should be received no later than the first of the month preceding the month of publication.

POSITIONS OPEN

DOCTOR RETIRING Established practice suitable for internist or family practice physician (with or without OB and PEDS) in southwest Michigan city. Beautiful multi-office building with X-ray, lab, etc. Three fully-equipped exam rooms including EKG, ultrasound and pulmonary function. Prime location near hospitals. Reply to Box 122, *Michigan Medicine*, P.O. Box 950, East Lansing, 48826-0950.

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PEDIATRICIAN, GENERAL INTERNIST OR FAMILY PRACTITIONER (husband/wife team?) for multi-specialty clinic 50 miles southeast of Chicago in university town in Dunes country of southern Lake Michigan. Superior schools, many recreational opportunities, small town atmosphere. Pediatrician to join long-established pediatrician with extensive practice. Four minutes from 400-bed hospital with NICU, ICU and CCU. Contact Thomas Covey, MD, FAAP, (219)462-4167.

FAMILY PRACTICE PHYSICIANS- BC/BE, two positions available. Two-man group and solo practitioner each seeking additional physician for rapidly expanding practice. Located in southern Florida near Ft. Lauderdale. Excellent opportunities with partnership potential after first year. Negotiable salary with incentives, liberal benefit package. Please send CV to Virginia K. Norquist, Nu-Med Hospitals, 16633 Ventura Blvd., 13th Floor, Encino, CA 91436.

FAMILY PHYSICIAN to replace retired member of five person busy suburban practice. OB optional, experience desirable. Contact John P. Newton MD, Plainfield Medical Center, Grand Rapids, MI 49505. Phone (616)364-7015.

ANESTHESIOLOGIST to join group consisting of 4 anesthesiologists and 3 CRNA's. Must be board eligible or board certified. Established PC with many fringe benefits in effect. Send CV to Associated Anesthesiologists of Saginaw, PC, 3121 Davenport, Saginaw, Michigan 48603 or call (517) 791-2150.

PEDIATRICS Marshfield Clinic, a 250-physician, multi-specialty private group practice, is seeking a board certified or eligible general pediatrician to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent to a 110-bed JCAH accredited hospital. Competitive salary and fringe benefit package. Send curriculum vitae and references to: Mr. David Draves, Director, Regional Development, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449. Or you may call collect at (715)387-5376.

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FAMILY PRACTITIONER or internist. Full or part time. May be semi-retired for physicians office in the Southfield, Lathrup area. Call Richard Corey, Administrator (313)557-5155.

FAMILY PRACTITIONER AND INTERNAL MEDICINE SPECIALISTS to join seven-doctor Family Practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well-equipped 77-bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First-year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact: John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

BOARD CERTIFIED OR BOARD ELIGIBLE with good OB experience or Board certified or Board eligible OB/GYN to join busy Family Practice/OB GYN. Desirable area to live and raise a family. Salary open first year, partnership after first year. Reply to: 3436 S. River Rd., St. Clair, Michigan 48079 or call Pat at 313/329-7056.

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INTERNAL MEDICINE OPPORTUNITY High caliber, patient-oriented internist with or without sub-specialty, desired for rapidly expanding practice. Excellent potential. Contact Susan E. Coleman, MD, Medical Director, Womens Health Center of Clarkston. Phone (313)625-6660.

PART-TIME RADIOLOGIST needed for occasional weekend and vacation coverage. Busy hospital based practice within one hour of Lansing and Ann Arbor. Senior residents and fellows eligible. Practice includes CT, nuclear medicine, ultrasound, and mammography. Please reply to: Box 122, *Michigan Medicine*, P.O. Box 950, East Lansing, 48826-0950.

MICHIGAN: Emergency department directorships, full-time and part-time opportunities available throughout the state. Rural and urban locations. Guaranteed hourly rate and malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

MICHIGAN, ANN ARBOR-DETROIT AREA: Looking for career-oriented emergency physicians board certified/prepared in emergency medicine, internal medicine, surgery or family practice. Directorships with stipends available. Excellent compensation including malpractice insurance. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

CENTRAL INDIANA Witham Memorial Hospital, located in prosperous residential, farming community 25 miles from Indianapolis on major interstate hwy, is actively recruiting OB/GYN, orthopedic and several family practice physicians. Several group or solo opportunities available. Willing to negotiate base salaries and perks if desirable. Location offers excellent opportunity to build private practice plus low malpractice rates. Contact John Riekena, Administrator, Witham Memorial Hospital, P.O. Box 1200, Lebanon, IN 46052. (317) 482-2700.

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FAMILY PRACTICE NEWBERRY, MICHIGAN. Helen Newberry Joy Hospital is looking for a family practice physician to add to our staff. Will join five other doctors to provide care to a Northern Michigan town. Should be graduate of family practice residency program. Competitive salary, malpractice insurance, office space and other benefits. Contact Tom Hicks, Administrator, Helen Newberry Joy Hospital, Newberry, Michigan 49868, (906)293-5181.

PHYSICIAN WANTED to practice industrial medicine, full time in the Grand Rapids area. Guaranteed salary and fringe benefits including paid malpractice insurance, vacation and CME. Please send CV or call John P. Tagett, MD, medical director, Grand Rapids Industrial Clinic, 678 Front Street N.W., Grand Rapids, MI 49504 (616) 456-1445.

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MISCELLANEOUS

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THANKS TO OUR ADVERTISERS

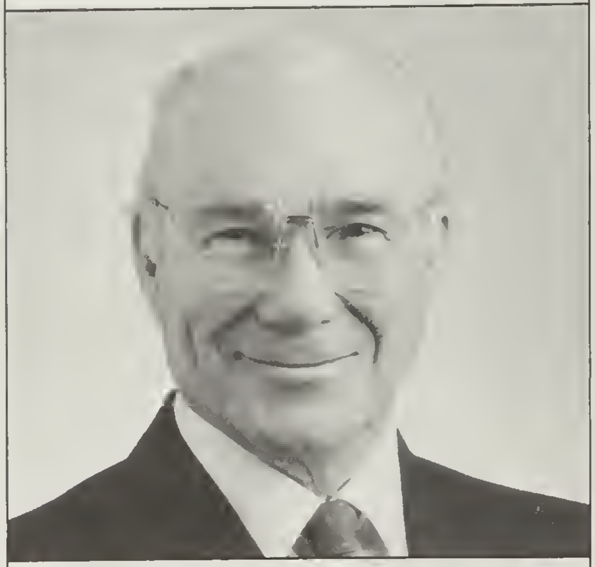
Advance Medical & Research Ctr., Inc.	277
Ayerst	265-266
Bennethum Computer Systems, Inc.	294
Blue Cross Blue Shield	263
Brown Pharmaceutical Inc.	261
Cardiology Board Review	305
Family Practice Recertification	309
Group Health Inc.	294
Hosp. & Health Serv. Credit Union	299
Key Pharmaceuticals, Inc.	281-282
Laboratory of Clinical Medicine	295
Lilly	269
M-Labs	285
Manufacturers Bank	271
Marion Labs	282-283, 301-302
Medical Billing Service	297
MI Dept. of Corrections	286
MI Health Billing & Collection Service	267
MI Occupational Medical Association	309
MPMLC	273
Munson Medical Center	303
Palisades Pharmaceuticals, Inc.	292
PICOM	289
Roche Labs	320
Smith Kline & French	319
Stratton-Cheeseman & Assoc., Inc.	307
Trans Global Tours	305
U.S. Air Force	293
U.S. Army	284
Wayne State University Medical Alumni	296

A committee of one

By Frederick W. Bryant, MD

Editor's note: Frederick W. Bryant, MD, a Royal Oak ophthalmologist, assumed the office of MSMS president Saturday, April 30 at the MSMS House of Delegates meeting at the Hyatt Regency Hotel in Dearborn. Below marks Doctor Bryant's first President's Page in *Michigan Medicine*.

An indepth profile of Frederick W. Bryant, MD, can be found in this month's issue of *Michigan Medicine* beginning on page 270.



Doctor Bryant

"Over the years, I've become familiar with most of the MSMS Committees and count many members as my friends."

Committees and Task Forces are cornerstones and building blocks of organized medicine's house. Sometimes born in fire, they can be vigilant and combative, much like Paul Revere, sounding alarm, spreading the word, and rallying Minutemen. In other serene circumstances, they more nearly resemble colonies of bees, industriously attentive to daily rituals, assiduously refining performance patterns, and building for the future. Together, these catabolic and anabolic qualities, one kinetic and consuming, the other cumulative and conserving, give MSMS a palpable pulse of circulating energy while nurturing its maintenance and growth requirements.

Committeemen (male and female) are, in a true sense, elite. They either accept positions offered them because of conspicuous admirable traits they display, or they ask to participate, indicating interest and willingness to serve. In order to belong, they must rise above disinterest, dissent, cynicism and the press of daily affairs. Volunteers without pay, theirs is love's labor, the only reward betterment of the public weal, the only profit improvement of the system that provides it.

And so, if you listen, you can hear a steady, productive hum of activity at MSMS headquarters in East Lansing—the hive thrives! In fact, the village green is so crowded there are days when it's tough to find a place to park.

Over the years I've become familiar with most of the MSMS committees and count many members my friends. A committee of one, my purpose here is to herald your efforts and to thank you for that unique beneficence only you can give—your time, talent and energy in an altruistic cause. That's High Society! ☐

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:
Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) Injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L73B Date of issuance Apr. 1987

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In peptic ulcer:

RELIEF
REASSURANCE
REWARD

Tagamet®
brand of cimetidine
First to Heal

You'll both feel good about it.

RESULTS

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We need someone to fill a unique job opening. Someone to spend two years in another country. To live and work in another culture. To learn a new language and acquire new skills.

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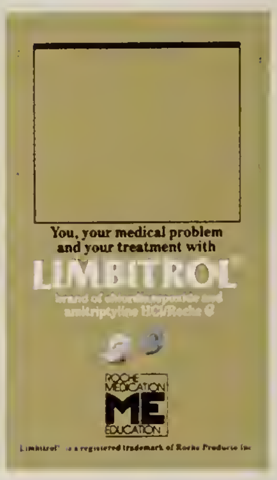
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LIMBITROL
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Roche Medication Education Booklets supplement your instructions to patients. So forget **ME** not. The Limbitrol® (chloradiazepoxide and amitriptyline HCl/Roche) Ⓒ booklet is part of The Roche Medication Education Program.

This important program helps your patients remember and understand:

- What the medication is and why they are taking it
- The importance of staying with the prescribed course of treatment
- What foods and drinks to avoid
- Possible side effects

For a free supply of Limbitrol booklets, complete the coupon below and mail it to:
Professional Services Department,
Roche Laboratories, a division
of Hoffmann-La Roche Inc.,
340 Kingsland Street, Nutley,
New Jersey 07110-1199

NAME

STREET ADDRESS

CITY STATE ZIP

Roche Laboratories
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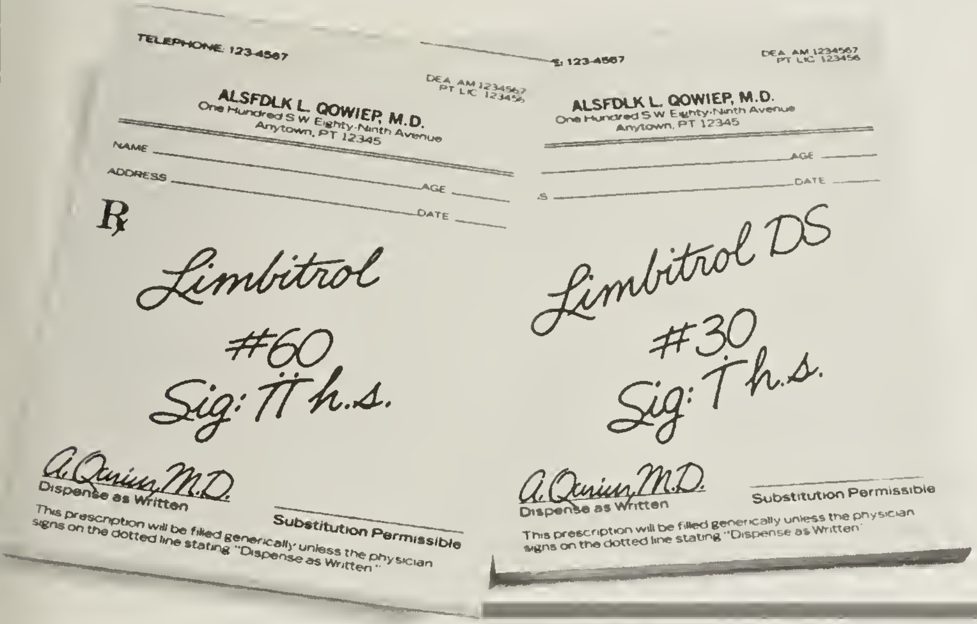
PLANDEX 35201

In moderate depression and anxiety

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



TELEPHONE: 123-4567

DEA AM 1234567
PT LIC 123456

ALSFDLK L. QOWIEP, M.D.
One Hundred S W Eighty-Ninth Avenue
Anytown, PT 12345

NAME

ADDRESS AGE

DATE

℞

Limbitrol
#60
Sig: ii h.s.

A. Quinn, M.D.
Dispense as Written

Substitution Permissible

This prescription will be filled generically unless the physician signs on the dotted line stating "Dispense as Written."

123-4567

DEA AM 1234567
PT LIC 123456

ALSFDLK L. QOWIEP, M.D.
One Hundred S W Eighty-Ninth Avenue
Anytown, PT 12345

AGE

DATE

Limbitrol DS
#30
Sig: i h.s.

A. Quinn, M.D.
Dispense as Written

Substitution Permissible

This prescription will be filled generically unless the physician signs on the dotted line stating "Dispense as Written."

Protect Your Prescribing Decision: Specify "Do not substitute."

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓒ

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓒ

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

Limbitrol® Ⓒ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

> ***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.
Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

ROCHE

ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

P.I. 0288

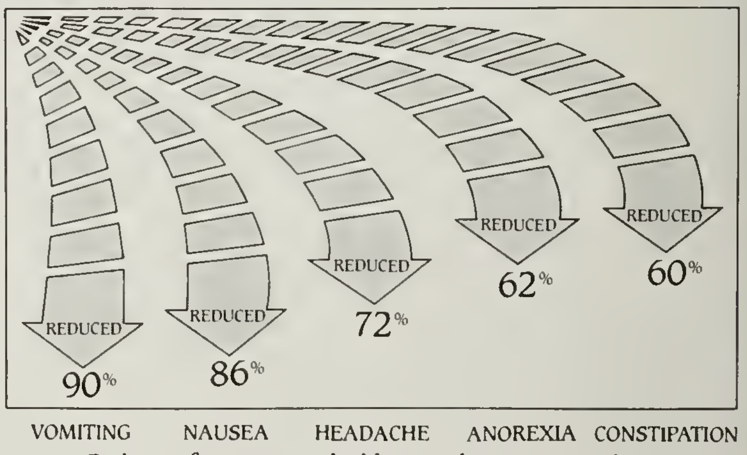
In the depressed and anxious patient

See Improvement In The First Week[1]...

And The Weeks That Follow

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week reduction in somatic symptoms[1]

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓒ-IV

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓒ-IV

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MICHIGAN MEDICINE

June 1988 Award-Winning Journal Of The Michigan State Medical Society Vol. 87, No. 6

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MSMS Physicians Recovery Network offers hope for impaired physicians

7 ways physicians can increase profits by leasing space in our ultra-modern, independent medical facilities

Farmbrook Medical Center of Sterling Heights
(Dequindre north of Metropolitan Parkway)

Farmbrook Medical Center of Southfield
(Telegraph north of 12 Mile)

1 PRESTIGIOUS MEDICAL FACILITY

Farmbrook Medical Centers are first-class, ultra-modern medical facilities, offering such features as independently heated and cooled medical suites so that tenants can control their own environments.

Our prestigious facilities coupled with spacious free parking provide the type of atmosphere that today's health care consumer is seeking

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Research has shown that consumers overwhelmingly choose their physicians within the immediate vicinity of their homes.

We therefore select our sites in densely populated, prime suburban areas making it convenient for a preferred patient base to easily reach its physicians.

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Due to the wide variety of physicians and other health care practitioners in a Farmbrook Medical Center, there is a built-in referral base. With a "medical only" tenant mix, every occupant in a Farmbrook facility is a potential source of increased revenue.

4 ON-GOING MARKETING CAMPAIGN

In today's competitive health care climate, Farmbrook Medical Centers is firmly dedicated to promoting its facilities through a multi-media marketing campaign

As consumers become more familiar with the Farmbrook name, they will be more likely to choose a physician in a Farmbrook facility for their health care needs.

5 DISCOUNTED RATES IN HOUSECALLS MAGAZINE

In order to create a vehicle for physicians to market themselves in an affordable manner, Farmbrook Medical Centers suggested the creation of a new health care magazine: HOUSECALLS.

HOUSECALLS contains feature articles about *local* physicians and is distributed in "neighborhood zones" where your patients live. Consistently reminding your market place about who you and what you do results in more business. Farmbrook tenants receive a 20% discount in marketing rates.

6 FREE MEMBERSHIP IN THE INDEPENDENT PHYSICIAN REFERRAL SERVICE

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New reimbursement policies and complicated claims form procedures are causing physicians to spend more time with paperwork. This means less time with patients and a loss of income.

To offset this problem, Farmbrook provides each tenant with free installation of a customized medical billing service computer system designed to eliminate paperwork problems.

Farmbrook Tenant Mix

Before moving your practice into a new facility it is important to know the present tenant mix to assess your referral potential. Below is a partial list of tenants in the Farmbrook Medical Center of Southfield:*

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- Women's Breast Center
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- Walk-in Medical Center
- Providence Hospital Family Practice
- Merit Laboratory
- Farmbrook Dental Group
- Plastic Surgery Affiliates
- Cardiology Associates (of Beaumont)
- Wright & Filippis
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For more information about how you can increase your profits in a Farmbrook Medical Center facility call

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* *Farmbrook Medical Center of Sterling Heights was recently completed and is now accepting lease applications*

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MICHIGAN MEDICINE

JUNE 1988 VOL. 87, NO. 6

Special Report

Narcotic addiction, alcoholism, organic brain disease, and mental illness are not discriminatory diseases. Anyone — physicians included — can become a victim. MSMS has, for 14 years, maintained a program to reach out to physicians who suffer from these diseases. Until 1987, the program was a volunteer one. Renamed the Physicians Recovery Network (PRN) last year, the professionally-staffed program now stands ready and willing to carry out the charge originally given the MSMS Committee to Assist Impaired Physicians. For the past year, PRN has been receiving referrals and questions and giving advice and direction to sick physicians. The problems physicians face, and the opportunities provided by the Physicians Recovery Network, are the subject of this month's special report. 324

Features

MSMS House of Delegates meeting
Photo highlights 343

Carl A. Gagliardi, MD — Exaugural Address
Doctor Gagliardi challenges physicians to get back to practicing medicine, not law 352

Physician's File
The first in a series of biannual reports about socioeconomic aspects of medicine and medical practice prepared by the MSMS Department of Medical Economics and Health Care Delivery 359

New MSMS Dental Plan
MSMS recently entered an exclusive contract with Delta Dental Plan of Michigan. MSMS members are encouraged to enroll now 364

How to run an efficient medical practice
The first in a series of articles on practice management — By John Anthony 369

Departments

In my opinion
"The system needs fixing!"
By Thomas R. Berglund, MD 322
Letters 323
Medical Newsfronts 374
Physicians in the news 378
Deaths 381
New Members 384
Category I courses 388
Meetings 390
Classified 393
Ad index 395
President's page
"Everything is relative"
By Frederick W. Bryant, MD 396

In next month's issue of *Michigan Medicine:* Blue Cross and Blue Shield of Michigan.

Cover photo by: Pace Media

IN MY OPINION

The system needs fixing!

By Thomas R. Berglund, MD

Everyone has read and heard all they can stand about the present tort system and how it relates to professional liability.

Nevertheless, I want to add my two-cents worth.

Two things haunted me as I left this year's House of Delegates meeting. First, MSMS leadership worked very hard with key legislators to develop a State Medical Liability Trust, then wisely backed away. The second thing was the recently-completed survey of residents, which found an overwhelming majority planning to leave Michigan because of the liability situation. This last *should* get the attention of the legislators, because the taxpayers pay a large portion of educating medical students and the public pays to train residents!

Doctor Berglund

The whole liability situation is steeped in myths and partial truths, which is no help when we try to find solutions. Much of the public (and legislators) believe all doctors are rich and increasing premiums only reduce our net incomes. This idea should die, along with the misperception that all doctors play golf and take Wednesdays off. I do neither.

Another falsehood is that insurance companies are making money hand over fist. Why have all the commercial companies left? MPMLC is a mutual company and is owned by the policyholders.

Your sponsored company, MPMLC, last year paid out about $36 million in indemnity payments and $12 million in defense costs. You know that attorney fees were at least one-third of the $36 million. Thus, we paid at least 50 percent to lawyers! Something is wrong with a system that pays the lawyers more

Continued on page 372

Doctor Berglund is a member of the MSMS Committee on Publications.

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LETTERS

Michigan Medicine article "well written"

We were very pleased to see the article "U of M Medical Center Performs the States First Brain Graft" by Susan Berman in the February '88 edition of *Michigan Medicine*. The article was extremely well written and would be very valuable for Parkinsonian patients.

We will be reproducing this article to appear in the *Michigan Parkinsonian* newsletter. We expect the article will appear either in our Spring or Summer 1988 edition.

Again, thank you for permission to reproduce the article.

David A. Nesbitt
Executive Director
Michigan Parkinson Foundation

Doctor Gagliardi praised for U.P. talk

Editor's note: In early March, Carl A. Gagliardi, MD, MSMS immediate past president, spoke at Iron County's Seventh Annual Medical Conference in Iron River. Below is a letter sent to Doctor Gagliardi (and his wife, Marj) regarding his visit.

I would like to thank both you and Marj for going out of your way to make an appearance at our conference at Ski Brule. I know that I speak on behalf of

Continued on page 386

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SPECIAL REPORT

MSMS program helps troubled doctors return to the mainstream

By Henry M. Domzalski, MD

You may have known it by its former name—the Impaired Physicians Program. The special MSMS service, however, is now the Physicians Recovery Network.

The new name was assumed in March, following approval of the MSMS Board of Directors. The purpose of the change is to emphasize the positive force of the program, which is designed to intervene in a confidential way with troubled physicians, and to return those physicians to the mainstream as quickly as possible.

The problems physicians face, and the opportunities provided by the Physicians Recovery Network, are the subject of this month's special report in *Michigan Medicine*.

MSMS initially embarked on this program in the 1970s to provide preventative medicine in this most serious of situations. Since that time, the Michigan Association of Osteopathic Physicians and Surgeons has become part of the program.

In the past two years, we have expanded and embellished the service.

We have hired a medical director, Gerald Vander Voord, MD, of Lansing, who provides a greater dimension to our efforts, and who can devote the time needed to make our program effective.

Doctor Domzalski is chairman, MSMS Steering Committee on Program to Assist Impaired Physicians.

Doctor Domzalski

Still, to accomplish our goals, and to provide the type of service we would like, we must have the help of physicians in their communities.

As chairman of the steering committee for the Physicians Recovery Network, I call on each county medical society to establish an impaired physicians committee. These committees then could assist our sick colleagues, with the ready assistance of our state-level program.

A few county societies already have such committees. Doctor Vander Voord plans to visit all other county medical societies in the near future to explain the state-level program, and to urge local committee appointments.

A feature of Doctor Vander Voord's county visits will be a slide presentation which describes the types of physician impairment and explains how the Physicians Recovery Network operates.

Members of the local committees intervene, on their own initiative, or at the request of family members, friends and colleagues. They investigate the situation and follow through in assisting physicians to obtain treatments.

To assist local physicians in providing this type of care for their colleagues, MSMS plans a series of intervention training seminars throughout the state. Participants will receive manuals explaining how the Network operates, how the county-level committees fit in the system, facilities available for referral and treatment, and the links to the Network.

These efforts take support and funding, of course. We thank those individuals who for many years have been part of the MSMS program and continue to be available when needed to help their colleagues.

In addition, we thank the Physicians Insurance Company o Michigan for its monetary support. PICOM wisely sees the program as an opportunity to practice risk management.

To gain additional funding those of us who are active with the program will continue to work through appropriate government agencies to seek legislative appropriations.

I invite you to read on, to learn more about the problems physicians face, and about how MSMS can help. ☐

Physician's Recovery Network is here to help you

By Gerald A. Vander Voord, MD

Narcotic addiction, alcoholism, organic brain disease, and mental illness are diseases that we believe, as physicians, that we can diagnose, treat, and follow. Yet, when we are faced directly with this problem in a patient, we often need to consult with a colleague with greater experience. Never failing to learn, we present the signs and symptoms, and get feedback as to the best course of action to take. We learn, the patient is treated, and a more suitable outcome ensures. Coronary artery disease, end-stage kidney disease, and malignancy are similarly treated, in that we present the patient's signs and symptoms to a colleague and get feedback.

The first four diseases are chronic, relapsing, progressive, and frequently fatal illnesses. The last three are very similar, but conjure up in us a much different feeling in regard to our participation in treatment. Fear of the disease, fear of stigma, fear of hospitalization are prevalent emotions in all their illnesses. It especially complicates the course of treatment when the patient is a physician.

MSMS has for 14 years maintained a program to reach out to sick physicians. Committees have worked diligently to define the problems, refine diagnostic criteria, extend caring assistance, and monitor the course of treatment. Our program was a volunteer one until 1987.

Doctor Vander Voord

> "The Network can do for the affected person what others are restrained from doing."

Today, we have the Physician's Recovery Network (PRN), which stands ready and willing to carry out the charge originally given the MSMS Committee to Assist Impaired Physicians. The PRN has been in operation for one year, receiving referrals and questions and giving advice and direction.

The program can be reached through the MSMS telephone number: (517) 337-1351. The calls are confidential and are referred to the medical director of the program, who establishes the contact to offer assistance.

Because there is fear and trepidation (and other factors) in making the contact, the program shoulders the tracks of identification, confirmation, intervention and referral for treatment.

The Physician's Recovery Network can do for the affected person what others are restrained from doing. The program already has established contacts with many physicians, and has helped them into recovery. But we continue to seek those who have difficulties due to the diseases of alcoholism, drug addiction, mental illness, and organic brain syndrome.

We know you don't know what to do with these diseases. We do. Call the Michigan State Medical Society (517) 337-1351 for assistance.

There are local physicians all around the state to help you! ☐

Doctor Vander Voord is medical director, Physician's Recovery Network.

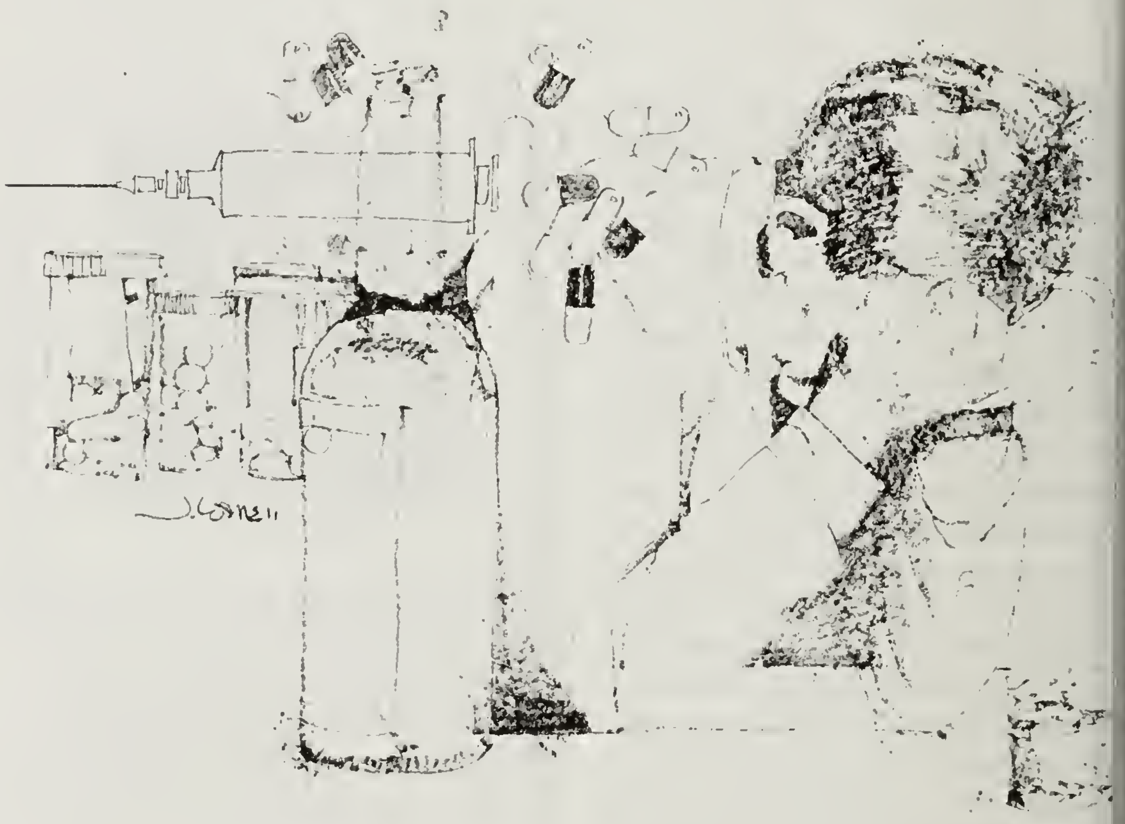
Physicians Recovery Network of Michigan

(517) 337-1351
120 West Saginaw St. East Lansing, MI 48826

SPECIAL REPORT

The physician and chemical dependence

By Thomas L. Haynes, MD



Chemical dependence is the protean disease of our generation, with the possible exception of AIDS. There is hardly a physician in active practice who does not encounter this disease on a regular basis.

For the purpose of this discussion, I will use the terms "addiction" and "chemical dependence" interchangeably. This condition should not be confused with the separate and distinct conditions of *chemical abuse* and *physical dependence*.

Chemical dependence is a genetically-induced, biochemically-expressed disease with psycho-social consequences. (Goodwin, D.W., et al., 1973; Bohman, M., et al., 1978, 1981, & 1984; Cloninger, C.R., et al., 1981 & 1983; and others.) The disease concept of chemical dependence states that addiction is a primary disease process, and that it has psycho-social phenomena associated with it which are consequences rather than causes.

Treatment which adheres to this concept has been much more successful in bringing the addict into recovery than treatment that views addiction as a symptom. This also means that the addict is not ultimately responsible for his or her disease of addiction, since without the genetic predisposition, the disease would never show up.

We do not yet have the technology to predict who is genetically predisposed, though such technology is on the horizon. So if we accept the disease concept as it is understood and presented here, why do we still allow ourselves to blame the addict for being addicted?

This is tantamount to blaming the diabetic for his or her disease.

A non-discriminatory disease

Various estimates have been made of the overall incidence of chemical dependence in our society. Most authorities will agree that this incidence is about 10 percent. Suffice it to say, a significant portion of any doctor's practice will include those with chemical dependence. This disease encompasses all ages, races, creeds, economic levels, and both sexes. As with other diseases tha find expression in multiple ways. a high index of suspicion is th first prerequisite in making th diagnosis. If a physician gets a inkling that addiction may b complicating the picture, it probably is.

Many physicians admit patients to the hospital who are no their own because of taking cal of the emergency department This means that they will encounter many patients who require hospitalization because o complications of their chemica dependence. Few of us need to b reminded that many of these people are not very desirable as patients, because of non-complianc with ordered treatments, demands for mood-altering chemicals, frequent lack of persona hygiene, and lack of family an

Doctor Haynes is a member, MSMS Steering Committee on Program to Assist Impaired Physicians.

financial support. They are often given the absolute bare minimum of therapeutic interventions, then discharged without the true underlying reason for their admission—their addiction—being addressed.

If the physician should try to address the presence of the addiction, he or she will usually meet with a wall of denial, which is symptomatic of the disease of addiction. Such denial serves to keep the disease active, and to keep the addict from the specific help he or she so desperately needs. With all of the above mechanisms in play, it is no wonder that there is an antipathy between physicians and addicts.

A conspiracy of silence

The physician who is addicted presents many uncomfortable situations to his or her colleagues. If the addiction is affecting the physician's coworkers and showing up in the hospital or office, it is already far-advanced. When a physician is addicted, his or her colleagues often act as if nothing is wrong. This has come to be known as the *conspiracy of silence*. The overall effect of this silence is to allow the disease to progress without diagnosis or therapeutic intervention. This vicious cycle then continues until the situation gets so bad that it can no longer be ignored. At this point the state medical board often gets involved, and the physician may receive punitive reactions to this disease rather than a therapeutic response.

Help is available

A new system which is designed to identify and help the addicted physician recently has been brought into being in Michigan, modelled after the very effective programs in New Jersey, Florida, Tennessee, New York, Pennsylvania, Arizona, and a few other states.

> "The stigma that is still attached to the chemically-dependent person affects how the physician views addiction and its complications."

In these programs there is a full-time (or occasionally part-time) paid physician who works for the state medical society to identify physicians who are having trouble due to alcohol, drugs, psychiatric illness, senility, or other problems, and to arrange for appropriate therapy, as well as to provide post-treatment follow-up, monitoring, and advocacy.

This type of program has generated much enthusiasm among knowledgeable and interested physicians and their medical societies.

Even though these physician recovery program directors will work with all types of difficulties, the vast majority are due to addiction to alcohol or drugs.

The Michigan State Medical Society's Steering Committee for the Impaired Physician has selected a very competent and caring physician to be its first paid medical director. That physician is Gerald Vander Voord, MD, of Lansing.

The stigma that is still attached to the chemically dependent person affects how the physician views addiction and its complications. As an example of this, one should consider the diagnoses which are entered on a death certificate once an addict dies. They include all the symptoms and secondary effects of addiction, such as traumatic events from motor vehicle accidents, cirrhosis of the liver, injuries from falls or fights, cardiomyopathy, gastrointestinal bleeding, hypertension, hemorrhagic stroke, and multiple other conditions that are directly caused by or are associated with chemical dependence.

Such identification of these immediate causes of death without mentioning the underlying process of addiction covers up the full toll that this disease takes from our society. This same error of mis-diagnosis or underdiagnosis occurs with hospital admissions, often supported by the stance of some health institutions of refusing to admit alcoholics or addicts.

Continued on next page

DEPENDENCE/Continued

It is generally estimated that when all these effects are considered, chemical dependence is the third leading cause of death in the United States, behind heart disease and cancer.

Prescribe drugs carefully

One of the best ways the physician can help addicts is to avoid becoming subject to their search for drugs through the prescription method.

There are four ways that a physician's prescribing practices can come to the attention of the Medical Board. They are by the physician being *disabled, dishonest, duped,* or *dated*. The *disabled* physician has been addressed above. The *dishonest* physician will enter improper prescribing practices because of secondary monetary or sexual gain. The *duped* physician is either tricked by the manipulative or malingering patient, or brought to improper prescribing by means of blackmail.

The *dated* physician has not kept up on modern prescribing practices.

Keep up-to-date

It is the physician's duty to keep up on the latest methods addicts are using to obtain and use drugs so that he or she does not become an unwitting accomplice to this process.

The final way that physicians will have an impact upon the addicted patient is through the referral process.

It is most important, once addiction has been identified in a patient, that the patient be referred to specialists who are comfortable and competent in treating chemical dependence as the primary disease that it is. We know today that in order to recover, the addict must remain abstinent from the use of *all* mood-altering chemicals.

> **"It is the physician's duty to keep up on the latest methods addicts are using to obtain and use drugs so that he or she does not become an unwitting accomplice."**

Physicians who are interested in learning more about the process of recovery should attend some open Alcoholics Anonymous or Narcotics Anonymous meetings. Whether the physician refers to AA, NA, or competent treatment facilities, he or she should be familiar enough with the processes of addiction and recovery to be an effective support mechanism for the recovering addict. It is especially important that the physician avoid the prescription of mood-altering drugs and that he or she encourage the continuing effort needed for long-lasting recovery.

There are many ways that a physician will encounter and affect those with the disease of chemical dependence. But the most dangerous encounters will only come as a result of ignorance about this important and prevalent disease. In order to be an effective physician for these patients, one should be knowledgeable, compassionate, supportive, and at times, confrontive. But none of these attributes will be effective if the physician is ignorant of what addiction is and how it is treated. ☐

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Organic mental disorders and the issue of retirement

By Stephen C. Mason III, MD

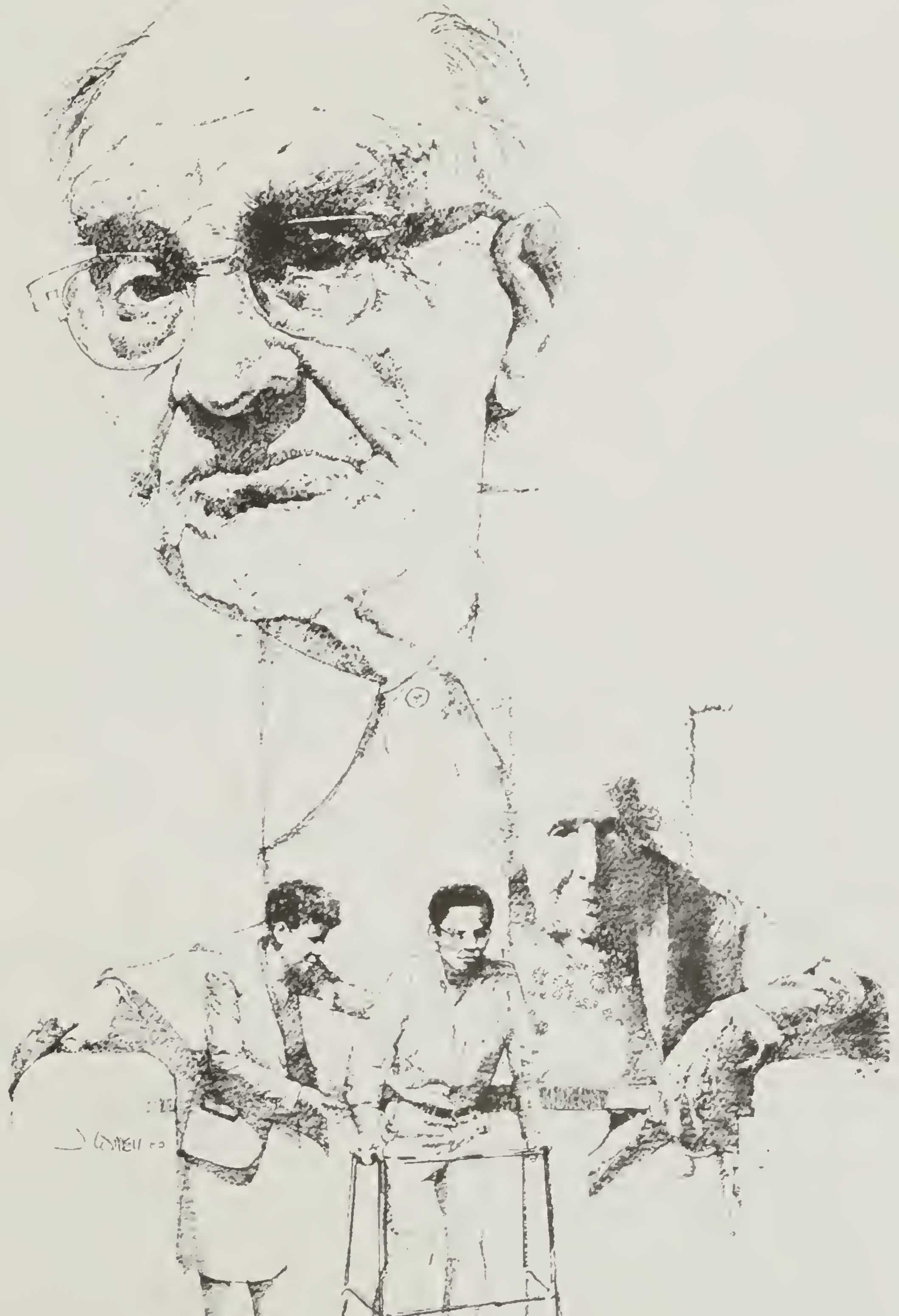
Physicians, like all humans, are subject to organic mental disorders. Any time one of these disorders is severe enough to affect the skill and judgement of the physician, it brings into question the advisability of that doctor continuing to practice medicine.

Fortunately, some of these conditions are reversible or self-limiting.

However, when permanent damage to the central nervous system has been sustained, the hope of recovery of function is minimal. In the case of a progressive disorder, the outlook is bleaker.

A brief review of the organic mental disorders will put this diagnostic area into better perspective. An "organic mental disorder" is a diagnostic label given to a particular organic brain syndrome when the etiologic agent is known or assumed. For example, multi-infarct dementia, or alcohol-withdrawal delerium, would be specific organic brain disorders. "Organic brain syndrome" is a clinical term used to describe a constellation of psychological and behavioral signs and symptoms, without reference to etiology, that result when the integrity of the central nervous system is disrupted.

The types of reaction to these organic insults are limited, the most common being delerium, dementia, intoxication and with-



Doctor Mason is a member, MSMS Steering Committee on Program to Assist Impaired Physicians.

Continued on next page

ORGANIC/Continued

drawal.

The other, less-commonly seen, organic brain syndromes affect more circumscribed areas of mental functioning and cause such conditions as organic delusional syndrome, organic affective syndrome, organic personality syndrome or organic hallucinosis. The causative agent bringing about these changes in mental function can be a primary brain disease, or a systemic illness that affects the brain secondarily, or a substance or toxic agent that affects the brain function directly.

There are a great many entities that affect the human brain, and as a result the number of organic brain disorders will be accordingly large. Anything that interferes with the integrity of the central nervous system will affect its function. The resulting disturbance will vary with the offending agent, its location in the brain and the extent and duration of its effect. It can bring about a wide range of emotional and behavioral effects, as well, which make it difficult to decide whether you are seeing a direct result of the brain insult or a psychological reaction to the deficit. Decreased control of sexual, aggressive or acquisitive impulses can accompany the cognitive impairment. Impaired judgement as well will further complicate the picture.

For the remainder of this paper, the focus will be on the aging process and the mental changes that it brings about. This is not to diminish the importance of delerium and intoxication as important considerations in physician impairment. But these will be covered in other contexts. Our main focus will be on the progressive brain changes that take place with aging.

Whether it is a primary degenerative dementia or a more benign senescent change, the type of pathological change appears to be almost identical. The main difference seems to be the speed at which the plaques and fibrillary tangles accumulate in the brain. The resulting loss of cognitive function, impairment of thought, judgement and control follows a similar progressive pattern. For a person like a physician, who depends so much on intellectual acuity and judgement in the performance of his duties, a disturbance in occupational function will be an early result as the first signs of dementia make their appearance. This makes it critical to keep a sharp eye on the changes occuring in the so-called benign senescence. No one is immune to the process of aging. A person of 50 years already has measurable changes in the nervous system and these progress at a rate that varies from individual to individual. The changes at first are subtle. The ability to learn and retain new information is not as good as it was in younger years. Lapses of memory and difficulty in recalling names and specifics become more apparent. Information that the doctor has depended on for years is not as quickly recalled or is lost. It becomes increasingly difficult to keep pace with the rapid changes in medical knowledge and as a result the doctor begins to fall behind. The net result is that the doctor's standard of practice is gradually deteriorating and his other clinical judgement slowly is being compromised. Furthermore, during periods of fatigue, anxiety or discouragement, the symptoms of the organic deficit are likely to be augmented. At these times, episodes of definite impairment in judgement and performance are likely to appear. The result can be catastrophic.

> "No one is immune to the process of aging. A person of 50 years already has measurable changes in the nervous system."

What must a physician do when he or she begins to notice some of these changes? One smart move would be to lessen pressures. The physician can take on fewer of the difficult and de-

Continued on page 334

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C I B A

References: **1.** Data on file, CIBA Pharmaceutical Company **2.** Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. **3.** Skoutakis VA, Carter CA, Acchiardo SR Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics *Drug Intell Clin Pharm* 1987;21:436-440

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

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1 For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis

2 For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases In more severe cases supplementation with potassium salts may be indicated

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e g , spironolactone, triamterene) (see OVERDOSAGE)

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium

WARNINGS

Hyperkalemia (See OVERDOSAGE)

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally Potentially fatal hyperkalemia can develop rapidly and be asymptomatic

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g , spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and or ulcerative lesions of the small bowel and deaths These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs

Metabolic Acidosis

Hypokalemia in patients with metabolic *acidosis* should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per* se can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per* se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium

Information for Patients

Physicians should consider reminding the patient of the following

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed This is especially important if the patient is also taking both diuretics and digitalis preparations

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis

Drug Interactions

Potassium-sparing diuretics: see WARNINGS

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity Slow-K should be given to a pregnant woman only if clearly needed

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L It is not known if Slow-K has an effect on this content Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose

Skin rash has been reported rarely

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6 5-8 0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion Large numbers of tablets should be given in divided doses

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets — 600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

Bottles of 100	NDC 0083-0165-30
Bottles of 1000	NDC 0083-0165-40
Consumer Pack — One Unit	
12 Bottles — 100 tablets each	NDC 0083-0165-65
Accu-Pak® Unit Dose (Blister pack)	
Box of 100 (strips of 10)	NDC 0083-0165-32

Do not store above 86°F (30°C) Protect from moisture Protect from light

Dispense in tight, light-resistant container (USP)

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

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ORGANIC/Continued

manding cases and procedures. He or she can refer these to younger colleagues, see fewer patients, take a salaried job with less demand for mental acuity. These can be the first of a set of changes that could be initiated as part of a plan for eventual full retirement. The day surely will come when retirement is a necessity. It is less disruptive in the doctor's life if that day has been planned for with pleasant expectations of what's to come.

Why do many doctors resist retirement so vigorously? There are many reasons, and each doctor will have his or her own, probably well-rationalized. There also will be underlying causes that likely are more important and compelling.

It is understandable that this is no small decision. To many it means giving up a way of life and a reason for being. Most doctors make a decision to study medicine fairly early in life and then are committed fully to the profession in the ensuing years. It is the central focus of their lives. Leaving it behind almost amounts to a loss of identity. The more the doctor has depended on this medical identity to make life worthwhile and rewarding, the more of a loss will be felt with retirement.

At this time it will help to reactivate early interests and friendships that have been postponed because of the demands of the practice. New undertakings can help the doctor feel useful and important. Retirement should not be equated with senility—those years usually are a long way off. There still is time to enjoy the freedom from the pressures and responsibilities of a medical practice and to experience a more relaxed enjoyment of life. Opportunities to make a contribution still are open by volunteering services in research activities, at State hospitals or as a locum tenens. Other volunteer positions are available and can be rewarding. Getting together with retired colleagues for recreational or other social purposes can be enjoyable. Each doctor can find his or her own formula for fulfillment.

In the event that a practicing doctor will not acknowledge signs of impairment, what should a colleague do? It will be best if the deficiencies are brought to the doctor's attention, this being done in as understanding and supportive a way as possible. The subject of impairment will thus have been opened up and the doctor made aware of what colleagues are noticing. At least a start will have been make in breaking down the denial process that has kept the situation outside the doctor's awareness.

If the doctor accepts the information and moves ahead to implement the advice given, the objective has been achieved. If not, it will be necessary to get other persuaders. The local affiliate of the Physicians Recovery Network (part of the Program to Assist Impaired Physicians) is the appropriate place to seek help. PRN members will make a careful evaluation of the problem and recommend a course of action. They will see that it is followed. If problems persist you can contact the Physicians Recovery Network at MSMS Headquarters. ☐

SPECIAL REPORT

An Auxiliary point of view

By Bev Jensen

Within the medical family we see alcohol affecting each member differently. We need a spouse support group within the medical family that can help these people, be they a physician or the spouse of a physician, to get to AA and Al-Anon and therapy. It doesn't matter who you are at these meetings; you attend because of the presence of alcohol in your life.

Many times a marriage suffers. Many lies are told to family, colleagues, and patients. There are increasing mood swings with the disease of alcoholism. The loneliness increases because the sick member withdraws more and more into his/her world of alcohol, shutting out the rest of the world, that really means the most to them. Many family members of the alcoholic go into their closets and hide because the hurt is so bad.

Here are the steps to be taken for recovery:

- Help on a one-to-one basis
- Intervention
- Education in medical meetings and Auxiliary meetings, so that colleagues are better informed about this disease

After a member is in recovery please don't turn your back on such a member. When you invite

Continued on next page

The author serves as MSMS Auxiliary representative, Steering Committee on Program to Assist Impaired Physicians.

The following steps/traditions are provided by Alcoholics Anonymous

THE TWELVE STEPS		THE TWELVE TRADITIONS
We admitted we were powerless over alcohol — that our lives had become unmanageable.	1	Our common welfare should come first; personal progress for the greatest number depends upon unity.
Came to believe that a Power greater than ourselves could restore us to sanity.	2	For our group purpose there is but one authority — a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
Made a decision to turn our will and our lives over to the care of God *as we understood Him.*	3	The relatives of alcoholics, when gathered together for mutual aid, may call themselves an Al-Anon Family Group, provided that, as a group, they have no other affiliation. The only requirement for membership is that there be a problem of alcoholism in a relative or friend.
Made a searching and fearless moral inventory of ourselves.	4	Each group should be autonomous, except in matters affecting another group or Al-Anon or AA as a whole.
Admitted to God, to ourselves and to another human being the exact nature of our wrongs.	5	Each Al-Anon Family Group has but one purpose: to help families of alcoholics. We do this by practicing the Twelve Steps of AA *ourselves,* by encouraging and understanding our alcoholic relatives, and by welcoming and giving comfort to families of alcoholics.
Were entirely ready to have God remove all these defects of character.	6	Our Al-Anon Family Groups ought never endorse, finance or lend our name to any outside enterprise, lest problems of money, property and prestige divert us from our primary spiritual aim. Although a separate entity, we should always cooperate with Alcoholics Anonymous.
Humbly asked Him to remove our shortcomings.	7	Every group ought to be fully self-supporting, declining outside contributions.
Made a list of all persons we had harmed, and became willing to make amends to them all.	8	Al-Anon Twelfth-Step work should remain forever nonprofessional, but our service centers may employ special workers.
Made direct amends to such people wherever possible, except when to do so would injure them or others.	9	Our groups, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
Continued to take personal inventory and when we were wrong promptly admitted it.	10	The Al-Anon Family Groups have no opinion on outside issues; hence our name ought never be drawn into public controversy.
Sought through prayer and meditation to improve our conscious contact with God *as we understood Him,* praying only for knowledge of His will for us and the power to carry that out.	11	Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, TV and films. We need guard with special care the anonymity of all AA members.
Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs.	12	Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles above personalities.

AUXILIARY/Continued

that person out, don't treat that person as if you don't know how to cope with the situation.

A phrase in Al-Anon is: "Keep it simple." Al-Anon provides people with the tools to work through difficulties one day at a time. As we learn to accept our powerlessness and to turn our lives and our will over to a Higher Power we gradually break free from the negativity, hopelessness, and fragmented thinking that prevented us from living serene and harmonious lives. When we simplify our lives, focus our attention on ourselves, and let go of self-defeating complications we make room for our Higher Power. Keeping it simple means we don't second-guess the Higher Power; we let go of the "what if's," the microscopic re-examination of our problems, and the magnification of our misery. As we detach from the confusion our patience returns, and our serenity, and we begin to see our situation through the eyes of our Higher Power. ☐

> "Al-Anon provides people with the tools to work through difficulties one day at a time."

The "miracle" of recovery: one physician's story

I didn't know when my drinking stopped enhancing my social life and began controlling it; it was probably early in my drinking career. I can remember unpleasant consequences from drinking back to the age of 17, but that never stopped me from drinking.

Military service accelerated my drinking and my tolerance for alcohol rose tremendously. I was able to function physically and mentally after drinking large quantities of alcohol, quantities that would have anesthetized my friends.

After discharge, I returned to school and then entered medical school. My drinking was periodic and progressively punctuated by embarrassment and shame. School, internship, residency and practice constituted years of compulsive working with alternating periods of compulsive drinking. I became progressively depressed. Alcohol relieved the depression transiently, and I thought I drank because I was depressed. It never occurred to me that I was depressed because I drank. I was in the territory of suicide for years, making fumbling plans, particularly while drinking, but never carrying them out.

Finally, I drove into a tree, fractured four ribs, had a cerebral hemorrhage and was hospitalized. My blood alcohol on admission approached 400 mgs percent.

The author is an anonymous Michigan physician.

When I awoke in the hospital. I "surrendered." I knew that I needed help and I was ready to listen. Until that moment, I was unaware that there was anything to listen to. My depression, my drinking, seemed the logical result of multiple "causes."

The next six months were the most difficult for me. If I wasn't floating on pink clouds, I was in the depths of depression. If I wasn't enraged by some imagined or real slight, I was cowering in terror over some projected disaster.

As time went by and these highs and lows settled, I came to realize that these were normal feelings that I had anesthetized all these years with alcohol whenever they became uncomfortable Then I realized what an enormous change it was for me to give up alcohol. For the first time in most of my adult life I had to find an alternative way to live and cope with very uncomfortable feelings. AA had taught me, and continues to teach me, how to do this.

By going to meetings 2-3 nights a week, I keep the priorities I need straight. As long as I do this I can cope with the stresses and strains of life.

Alcoholism is a disease certainly of the mind, definitely of the body, and was, at least for me, fatal for the spirit. The miracle of my recovery to date has been a miracle of the spirit

I used to drink to feel good Now I work the steps of AA to feel good and it works. ☐

Clues to alcoholism or drug addiction in six areas of a physician's life*

Provided by the MSMS Steering Committee on Program to Assist Impaired Physicians

Community

- Isolation and withdrawal from community activities, leisure activities and hobbies, church, friends, peers
- Embarrassing behavior at club or parties
- Arrests for driving while intoxicated, legal problems
- Unreliability and unpredictability in community and social activities
- Unpredictable behavior, e.g., inappropriate spending, excessive involvement in political activities

Family

- Withdrawal from family activities, unexplained absences from home
- Fights, child abuse
- Development in spouse of disease of "spousaholism"
- Abnormal, antisocial, illegal behavior by children
- Sexual problems — impotence, extramarital affairs, contracultural sexual behavior
- Assumption of surrogate role by spouse and children
- Institution of geographic separation or divorce proceedings by spouse

Employment

- Numerous job changes in past five years
- Frequent geographic relocations for unexplained reasons
- Frequent hospitalizations†
- Complicated and elaborate medical history†
- Unexplained intervals between jobs
- Indefinite or inappropriate references
- Working in job inappropriate for qualifications
- Reluctance of job applicant to let spouse and children be interviewed
- Reluctance to undergo immediate preemployment physical examination

Physical status

- Deterioration in personal hygiene
- Deterioration in clothing and dressing habits
- Multiple physical signs and complaints
- Numerous prescriptions and drugs
- Frequent visits to physicians and dentists
- Accidents
- Emotional crises

Office

- Disruption of appointment schedule
- Hostile, withdrawn, unreasonable behavior to staff and patients
- "Locked-door syndrome"
- Excessive ordering of supplies of drugs from local druggists or by mail
- Complaints by patients to staff about doctor's behavior
- Absence from office — unexplained or due to frequent illness

Hospital

- Making rounds late, or inappropriate, abnormal behavior during rounds
- Decreasing quality of performance, e.g., in staff presentations, writing in chart
- Inappropriate orders or overprescription of medications
- Reports of behavioral changes from hospital personnel ("hospital gossip")
- Involvement in malpractice suits and legal sanctions against hospital
- Reports from emergency department staff of unavailability or inappropriate responses to telephone calls

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*Areas are usually involved sequentially, although two or three may seem to be involved simultaneously.
†Information obtained from employment applications.

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EAST LANSING, MI 48826-0950
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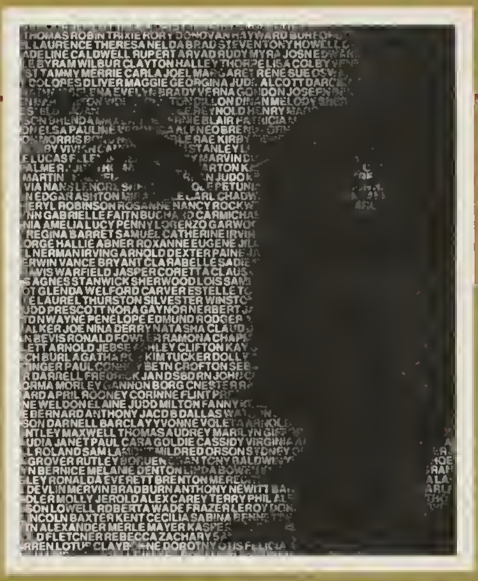

Please see brief summary of prescribing information.

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...like the more than one million patients who have received INDERAL® LA.

In a recent survey, 4,120 participating physicians gave us their views[1] on INDERAL LA in the treatment of hypertension, angina and migraine.

INDERAL LA is their preferred beta blocker

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated INDERAL LA good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe INDERAL LA.

INDERAL LA promotes patient compliance

...Virtually every responding physician rated patient satisfaction with INDERAL LA to be as good as, or better than, other beta blockers.

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

ONCE-DAILY
INDERAL® LA
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LONG ACTING
CAPSULES
60, 80, 120, 160 mg

The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

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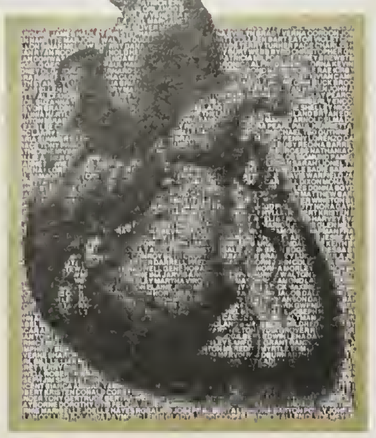

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INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES 60,80,120,160 mg

The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The addec catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardia contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of beta blocker and verapamil has resulted in serious adverse reactions, especially in patients wit severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, *phenobarbitone*, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels o both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly wit propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasin blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animal have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in bot rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-in duced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproduc tive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in anim studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be use during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised whe INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rare required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotensio paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud typ

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitud weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hall cinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time a place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased perfo mance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid drea appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constip tion, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching a sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, a Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the sk serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associat with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in sustained-release capsule for administration once daily. If patients are switched from INDER Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDER INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessa especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg on daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed full hypertensive response to a given dosage is variable and may range from a few days to seve weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once da dosage should be gradually increased at three- to seven-day intervals until optimal response obtained. Although individual patients may respond at any dosage level, the average optimal dosa appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 per day have *not* been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (s WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once da The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:
1. Data on file, Ayerst Laboratories.

D7295/188

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MSMS annual meeting mixes policy, politics, personality

elegates to the 1988 MSMS annual meeting April 29-May 1 in Dearborn refocused liability reform efforts, initiated a new section for graduates f foreign medical schools, and expanded the medical society's roles in peer review, AIDS education and access to medical care.

The delegates established MSMS policy through reference committees' open hearings, committee recommendations, and full votes on the floor. The hearings are working sessions like the one at left, conducted by Committee B, which dealt with professional liability issues.

Photos by Pattrick Yockey

Continued on next page

Then-MSMS Board Chairman Robert E. Paxton, MD, left, emphasized that "unity remains a prerequisite for any success we hope to achieve." Doctor Paxton was chosen MSMS president-elect during the meeting. On the dais with him were MSMS Legal Counsel Richard D. Weber, and then-Vice Speaker Robert D. Burton, MD.

Gerald H. Mandell, MD, who has served as speaker of the House of Delegates the past six years, received standing ovations for his service.

MSMS Secretary Robert M. Leitch, MD, left, swore Frederick W. Bryant, MD, into office as 1988-89 MSMS president. Doctor Bryant is a Royal Oak ophthalmologist.

1987-88 MSMS President Carl A. Gagliardi, MD, right, had the pleasure of presenting an MSMS National President Award to his brother, Raymond A. Gagliardi, MD. Raymond is president of the American Roentgen Ray Society.

Delegates mix business with humor during the annual meeting. Enjoying a good laugh above are, from left, David K. Johnson, MD, Omero S. Iung, MD, and Rolland E. Bethards, MD, delegates from Ingham County.

More photos on next page

An annual highlight of the House of Delegates meeting is presentation of pins to members in practice for 50 years. The Class of 1938 gathered, above, for their official portrait. Included is former MSMS Board Member Harvey M. Andre, MD, Grand Rapids, sixth from right in back row.

Robert M. Leitch, MD, past MSMS president and chairman of the board, received delegates' and officers' praise and gratitude as he retired after 30 years of MSMS leadership, the last 10 as secretary.

Doctor Gagliardi bestowed the MSMS President's Award upon James H. Har
rison, MD, right, retiring chief medical executive and deputy director of the Mich
igan Department of Public Health. Doctor Gagliardi praised Doctor Harrison fo
his distinguished service on behalf of the medical profession, particularly for hi
contributions in AIDS education, bioethics and environmental health.

Newly-installed MSMS President Fred W. Bryant, MD, belted out a few tunes with his after-hours combo, the "Heartbeats," at the pre-installation banquet reception.

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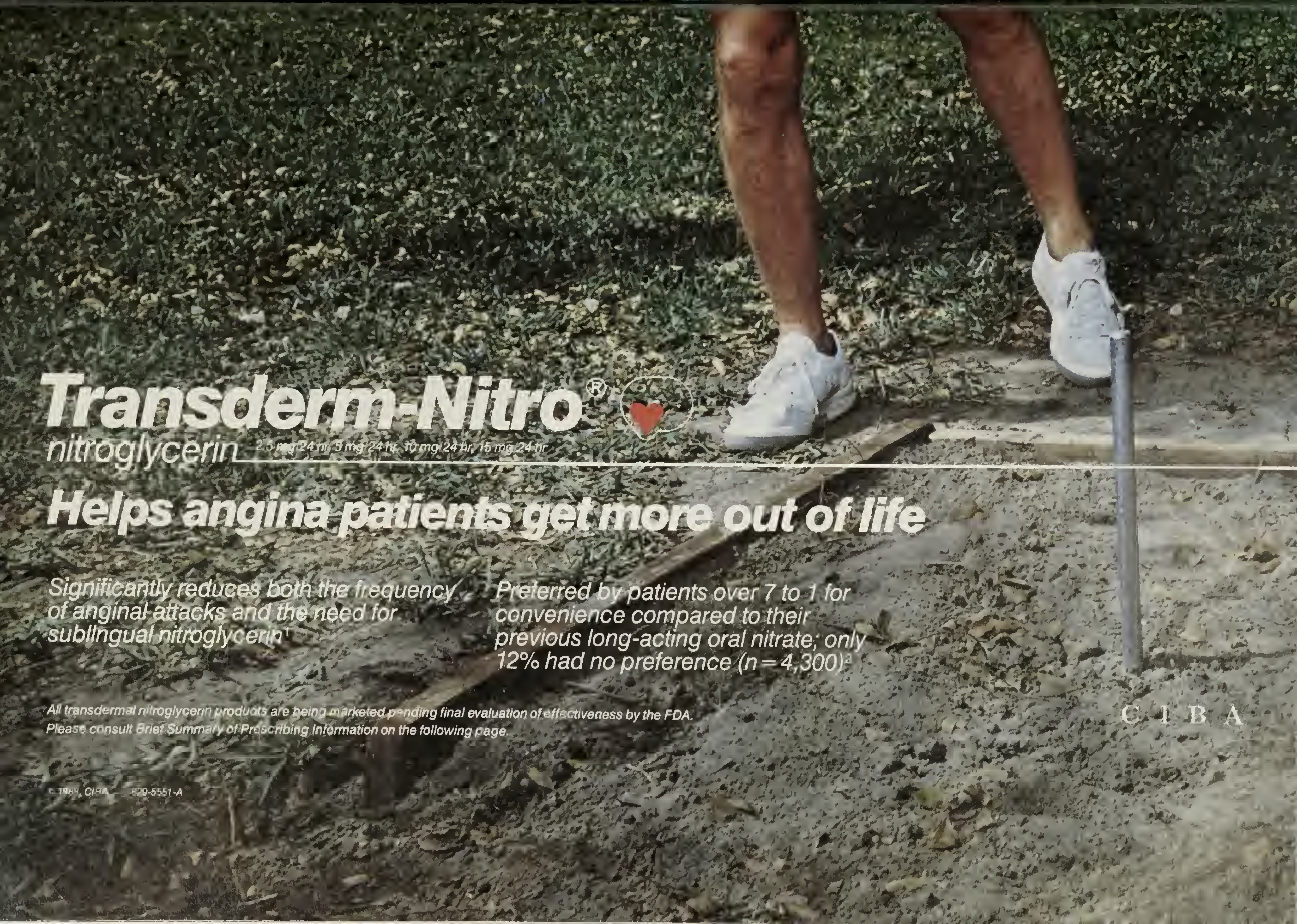

Transderm-Nitro®
nitroglycerin 2.5 mg/24 hr, 5 mg/24 hr, 10 mg/24 hr, 15 mg/24 hr

Helps angina patients get more out of life

Significantly reduces both the frequency of anginal attacks and the need for sublingual nitroglycerin[1]

Preferred by patients over 7 to 1 for convenience compared to their previous long-acting oral nitrate; only 12% had no preference (n = 4,300)[2]

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA.
Please consult Brief Summary of Prescribing Information on the following page.

© 1988, CIBA 629-5551-A

C I B A

Transderm-Nitro® nitroglycerin
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone. The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

Printed in U.S.A. *629-5551-A* C87-23(Rev. 7/87)

C I B A

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

1. Martines C: Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.
2. Brady EM, Gold OG, Rosenbach H: Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium. San Francisco, October 1987.

Cong. Hertel, Sen. Sederburg address MDPAC

Sen. William Sederburg (R-East Lansing) was one of the speakers for the 1988 annual luncheon of the Michigan Doctors Political Action Committee. The luncheon took place during the MSMS House of Delegates meeting at the Hyatt Regency Dearborn April 30. Sen. Sederburg told the group that though the worlds of physician and legislator vary greatly, the two must continue their dialogue.

Cong. Dennis Hertel (D-Detroit) told the MDPAC members that the key to the liability tort reform effort is to demonstrate how problems of the current system affect everyone. "You've got to show that your solutions meet the needs of all society," he said. Flanking him at the podium were MDPAC Chairman Peter A. Duhamel, MD, left, and MDPAC Secretary-Treasurer Mitchell A. Rinek, MD.

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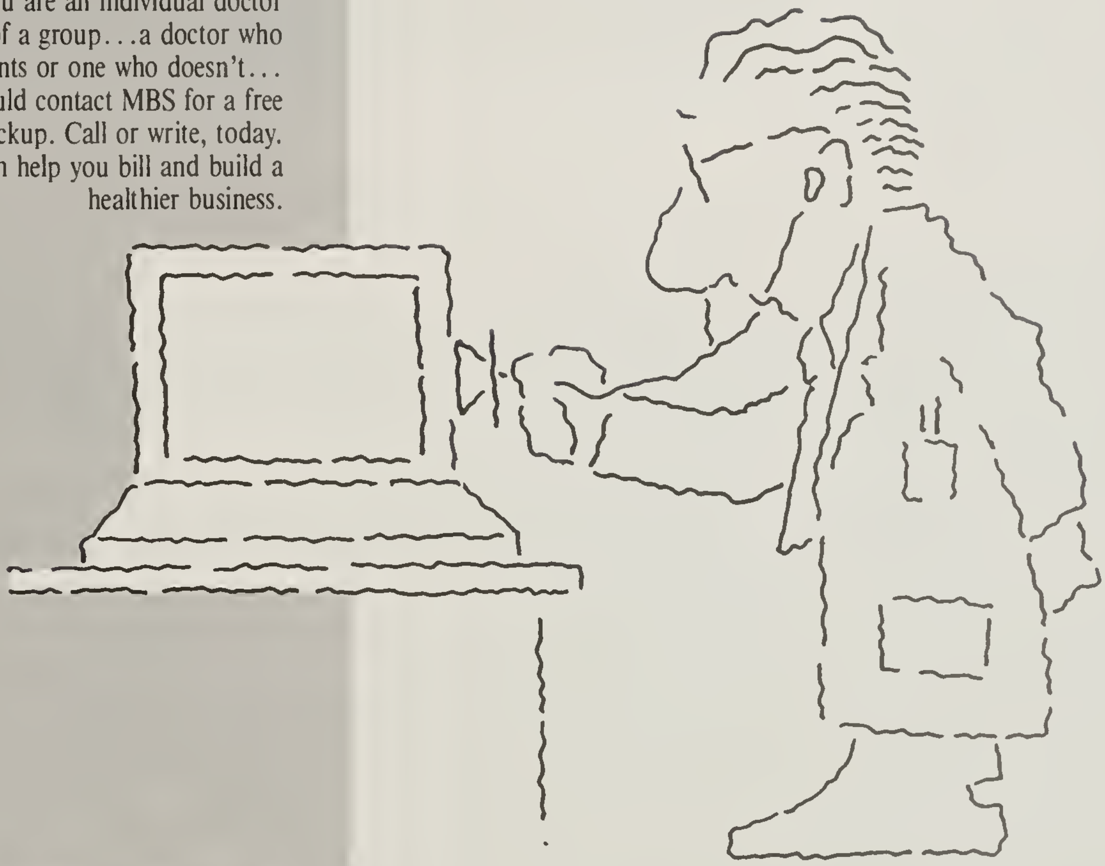
Whether you are an individual doctor or part of a group...a doctor who sees patients or one who doesn't... you should contact MBS for a free billing checkup. Call or write, today. MBS can help you bill and build a healthier business.



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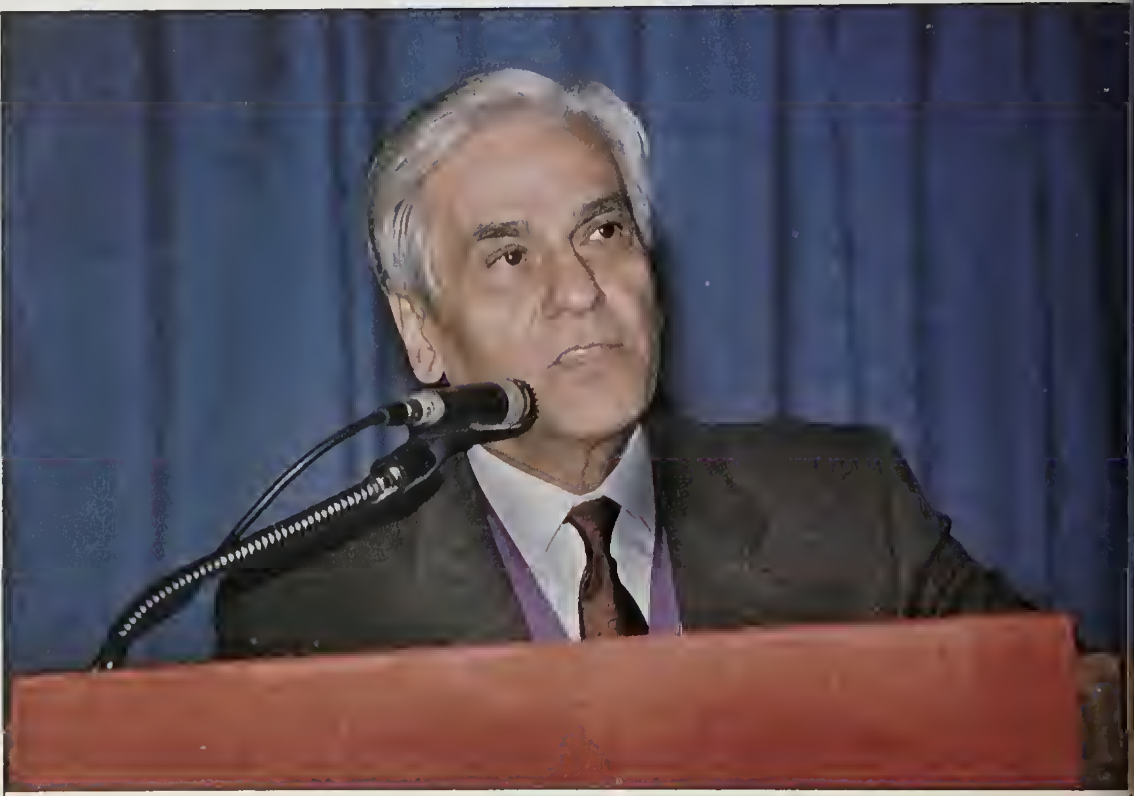
Exaugural Address

We need to get back to practicing medicine — not law, says Carl A. Gagliardi, MD

Editor's note: Carl A. Gagliardi, MD, MSMS immediate past president, earned a standing ovation after giving his exaugural address at the April House of Delegates meeting. His speech appears below.



Doctor Gagliardi posed several challenges to physicians in his exaugural address, many of which concerned overcoming the professional liability crisis.

It's never easy to say goodbye, but there comes a time when old leadership must step aside and make way for fresh faces and new ideas.

That time has come for me. I joined the medical society shortly after my arrival in Michigan to practice pediatrics with my wife in 1953, three and one-half decades ago.

Life is filled with coincidences that mold and shape our lives, and mine has been filled with just such coincidences. I was a math major in undergraduate school, headed for a career as an actuary, but World War II changed all that. I took postgraduate training in meteorology and subsequently became a specialist in tropical weather forecasting.

I fully expected that when the war was over, I would get a PhD in meteorology and spend the rest of my productive years sitting in front of weather maps.

Not so. An entirely different set of circumstances led me into medical school, and I shall be forever grateful for that detour. I have had a satisfying career, have met dedicated colleagues and close friends, but most of all, it was through medicine that I met Marj, a wonderful pediatrician, a great mother and a sensational wife.

Without her assistance, I could not have travelled this road.

Still another set of circumstances led me out of my beloved state of Connecticut here to Michigan where I practiced pediatrics privately for 27½ years before becoming director of medical education at Oakwood Hospital in 1980.

Not only has my career in pediatrics been pleasant and satisfying, so too has been my relationship with organized medicine. It has been an honor and a privilege to be chosen president of the Wayne County Medical Society, a delegate to both MSMS and the AMA, an MSMS board director and later it's chairman, and finally president of this great society.

When I assumed this presidency, I decided not to be merely your PR representative but rather an activist president, a statewide activist president. Last year at this time I promised you that I would go anywhere, speak with anyone who would hear me, and do anything within my power to seek a solution to the most distressing problem facing medicine today—this draining, straining liability crisis. I believe I have fulfilled that promise.

I have travelled from southeast Michigan to the western tip of the Upper Peninsula. I have spoken with members in Muskegon, Grand Rapids, Alma, Flint, Bad Axe, Pontiac, Mt. Clemens, Traverse City, Royal Oak, Novi, Saginaw, Escanaba, Iron Mountain and others. I have made

Continued on page 355

Announcing a new benefit beyond price alone.

Advanced Formula Mytrex®

(nystatin-triamcinolone acetonide)

New—fragrance-free formula

- ☐ Avoids the #1 irritant in cutaneous reactions[1]
- ☐ No methylparaben, propylparaben, or ethylenediamine
- ☐ Virtually nonsensitizing vanishing cream base

Uncompromised anticandidal effectiveness

- ☐ Faster, more thorough control of erythema and pruritus than nystatin or triamcinolone alone
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Convenience for compliance

- ☐ b.i.d. regimen
- ☐ Both popular dosage forms—cream and ointment

...and still economical

Please see facing [following] page for brief summary of prescribing information.

Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.

SAVAGE LABORATORIES
a division of Altana, Inc.
Melville, New York 11747

Mytrex® CREAM AND OINTMENT, USP

(nystatin-triamcinolone acetonide)

Brief Summary of Prescribing Information

For Dermatologic Use Only
Not for Ophthalmic Use

INDICATIONS AND USAGE: For the treatment of cutaneous candidiasis; it has been demonstrated that the nystatin-steroid combination provides greater benefit than the nystatin component alone during the first few days of treatment.
CONTRAINDICATIONS: This preparation is contraindicated in those patients with a history of hypersensitivity to any of its components.
PRECAUTIONS: General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings (see DOSAGE AND ADMINISTRATION). Therefore, patients receiving a large dose of any potent topical steroid applied to a large surface area should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests, and for impairment of thermal homeostasis. If HPA axis suppression or elevation of the body temperature occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function and thermal homeostasis are generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see PRECAUTIONS, Pediatric Use). If irritation or hypersensitivity develops with the combination nystatin and triamcinolone acetonide, treatment should be discontinued and appropriate therapy instituted.
Information for the Patient: Patients using this medicine should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occluded (see DOSAGE AND ADMINISTRATION).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.

Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid: Urinary free cortisol test; ACTH stimulation test.
Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.
Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetonide. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.
Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.
Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetonide Cream cleared or significantly ameliorated the disease state in most patients. *Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio.* HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.
ADVERSE REACTIONS: A single case (approximately one percent of patients studied) of acneiform eruption occurred with the use of combined nystatin and triamcinolone acetonide in clinical studies.
Nystatin is virtually nontoxic and nonsensitizing and is well tolerated by all age groups, even during prolonged use. Rarely, irritation may occur.
The following local adverse reactions are reported infrequently with topical corticosteroids. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and miliaria.
DOSAGE AND ADMINISTRATION: Cream: Apply MYTREX® (Nystatin-Triamcinolone Acetonide) Cream, USP to the affected area twice daily in the morning and the evening by gently and thoroughly massaging the preparation into the skin. Ointment. A thin film of MYTREX® is usually applied to the affected area twice daily in the morning and evening. MYTREX® should be discontinued if symptoms persist after 25 days of therapy. (See PRECAUTIONS, Laboratory Tests). MYTREX® should not be used with occlusive dressings.
Caution: Federal law prohibits dispensing without prescription.

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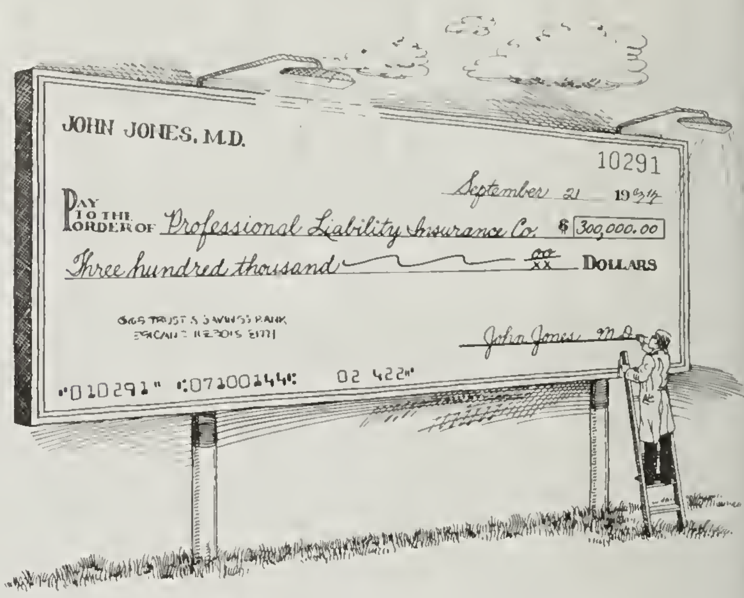
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A Sign of the Times?

In ten years, you could be paying far more for professional liability insurance than you now make in a year of practice.

The American Medical Association is fighting to keep liability costs under control: reviewing tort reform, working with national policymakers, promoting state coalitions to address the issue, distributing patient information material, an informing physicians on how to avoid lawsuits.

Do you want something done about professional liability? Join the AMA.

For information, call toll-free 800/621-8335
(in Illinois, call collect 312/645-4783), or write:

The American Medical Association
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ADDRESS/Continued

ountless trips to East Lansing nd our State Capitol. I have met ith Governor Blanchard, legisators from both Houses, editors nd reporters from the press, adio and TV. I have met with epresentatives of special groups, he American Association of Reired People, the Economic Allince, the Michigan Manufacturrs Association, the Chamber of ommerce, the Michigan Hospial Association, the State Bar of ichigan, the Michigan Trial awyers, the Michigan Liability nsurance Companies, the Citiens Lobby, National leaders in ongress and the AMA, and thers too numerous to mention. ou and I know there is a real risis, and I have done my best to onvince everyone else who ould listen that there is a real risis.

I believe this past year has been orthwhile, but I must admit it ould have been far more satisying, if I had been able to tell ou today that our problem has een solved. It has not.

ass exit no surprise

When I started to practice peiatrics in 1953, I carried 10,000-$30,000 liability insurnce coverage for an annual preium of less than $200. I can't emember the exact amount. hat was considered good coverge in those days. Today in the ri-county area (in southeast ichigan) a neurosurgeon or an orthopedist must pay $82,000 for a policy with $200,000-$600,000 limits, and there will likely be a 15 percent increase this year to bring the annual premium to the $94,000 to $95,000 range. Is it any surprise that bright young physicians are avoiding our beautiful state?

The legislators and regulators think there are too many physicians in Michigan, and I do too, but that will soon end if physicians who retire, quit for other reasons, move out of the state or die, are not replaced by well-trained, younger counterparts. A recent survey of Michigan residents in training show that 74 percent are leaving the state. They can't afford us unless some other party pays their monumental liability insurance premiums. As long as rates remain at this level, the brain drain will continue.

> **"I believe the vast majority of us are honest and dedicated and are practicing excellent medicine, and that the real truth is that the system has gone awry!"**

The amount of money we are pouring into this disastrous tort system is astronomical. In 1987 Michigan physicians paid $140 million in premiums, and Michigan hospitals contributed an additional $227 million. That comes to about one third of a billion dollars annually, and I must emphasize that I'm speaking only of Michigan. Yet this is not enough. The Fleming proposal called for an additional $140-$150 million annually in order to protect patients and physicians through the medium of a liability trust. That raises the kitty to one half of a billion dollars. Still not enough, according to the actuarial study supplied by the Michigan Hospital Association. Their actuaries claim that an additional $284 million, not $140-$150 million, would be needed to fund the liability trust. Now we're talking two-thirds of a billion dollars if we choose to believe the report of the hospital association's actuary.

Tort system has gone awry

With such funds one would have to believe that we as a group are practicing bad medicine. Rather I believe the vast majority of us are honest and dedicated and are practicing excellent medicine, and the real truth is that the system has gone awry!

Any system that requires one-half to two-thirds of a billion dollars annually to make ends meet, yet only returns 28 to 40 percent of the total to the plaintiffs, must be bankrupt or immoral or both.

Wonderful things have hap-

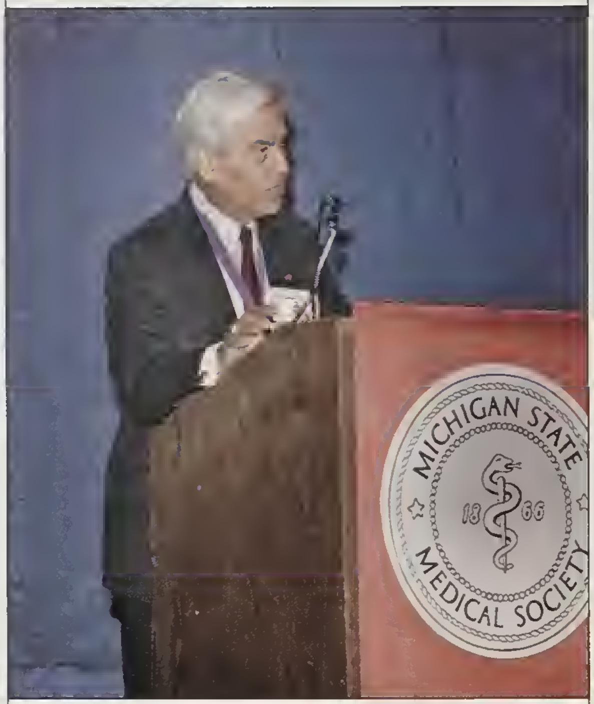
Continued on next page

pened in medicine during the past few decades. These have truly been golden years when one looks at the advances that have been wrought in medical care. The things we can do today stagger the imagination. Just think how much more we could accomplish if we could spend this one-half to two-thirds of a billion dollars on medical advances or medical assistance to the poor, the underprivileged and our senior citizens, rather than pouring it down the malpractice sewer. Remember my figures apply only to Michigan.

When you start talking about the US as a whole, we are talking billions upon billions of dollars.

Michigan liability climate is among the worst

On the other hand I must emphasize that the liability climate is significantly worse in Michigan than in much of the rest of the nation, certainly much worse than in our border states of Ohio and Wisconsin. For example, Michigan doctors who live in the Upper Peninsula near the Michigan-Wisconsin border are moving to Wisconsin and using the hospital on the Wisconsin side of the border despite the fact the hospital on the Michigan side is better-equipped and 41 years newer. In Toledo hospitals pay $2,000 per licensed bed per year to cover the costs of medical liability, while in the tri-county area in southeast Michigan, only 50-100 miles away, the average is $10,000 per licensed bed. A fine institution in the Detroit Medical Center, affiliated with the Wayne State University School of Medicine, pays a staggering $40,000 per bed per year. For Michigan as a whole, hospitals pay on average $6,000 in premiums for each licensed bed annually. How can anyone look at these figures and fail to recognize a dire situation?


Doctor Gagliardi

I repeat what I said earlier. All of us must stop blaming the problem on bad doctors because there are so few of them. No reputable physician condones their actions, and the Legislature must give the Board of Medicine the necessary tools to rid us of them. We must not be misled by these spurious arguments, but instead we must examine the root cause, the terrible tort system itself.

Some of my good lawyer friends tell me the tort system has served us well and should not be changed. I say hogwash! Nothing is so flawless that it does not need to be reviewed and revised from time to time. In this particular case it should be completely replaced with a more equitable and affordable system, and the time is now before our present crisis becomes an out-and-out-disaster.

Why then does the Governor not appoint a task force to look at alternatives to fix this broken system? Only he can answer that question.

Physicians are partly to blame for lack of a solution

My term as president officially ends tomorrow, but before I fade out of the picture, I would like to tell you some of my private thoughts on this problem. I do feel that we, as physicians, are partly to blame for the lack of a solution.

As long as we think of ourselves as only 11,000 physicians we have no clout—no clout at all. There are those of us who feel that way and resolutions are repeatedly introduced in our House of Delegates with the message that we just notify the public of our plight by means of newspaper advertisements or hired PR people or by some other means. I say that we are misjudging our own strength and we can do a better

Continued on page 358

When it comes to dental care, only one thing is as easy to use as Delta.

Frequent brushing is one simple part of maintaining healthy teeth. Another is Delta Dental—Michigan's first and largest group dental plan. As a pioneer in dental benefits, Delta has almost 30 years experience in making dental care affordable. And easy. And that helped make Delta Michigan's number one group dental plan.

So, when it comes to dental care, remember this simple plan: Brush often and use Delta. It'll keep you smiling for a long, long time.

Delta®
Dental Plan of Michigan
Right where you belong.

MSMS Members: Enroll Now!

ADDRESS/Continued

job of public relations, if we would only give ourselves a chance. We are not just 11,000 physicians. Surely we must be 20 times 11,000.

Each of us certainly has at least 20 patients and friends who understand our plight and will help us get our message across. If at first they don't appreciate the problem, we must teach them. You, our MSMS members, are our least costly, but surely the most effective, PR force we could put together. Your patients still respect and trust you. You're their physician, and they don't want to lose you. Talk with them, enlist their help, get them to join an army of voices screaming for reform. You can do this. You must do this! The alternatives are simply too painful.

Additionally we need to demonstrate much greater unity. I certainly don't pretend that we must or should agree at all times, but we should make a concerted effort to voice our differences internally and constructively as often as possible, and demonstrate unanimity externally.

Accentuate the positive, eliminate the negative

During the next two days that we are here together, I hope that you will debate the many tough issues we face, not only eagerly but thoughtfully as well. Then when we leave on Sunday I hope you will remember the words of the song and "accentuate the positive, eliminate the negative." Go forth with the voice of 220,000 voting citizens who will make every effort to move our agenda forward. No one would dare exclude the views of so powerful a block of voters.

In the long run we should be prepared to become as political as need be to accomplish our goals. If it seems down the line that a voter's initiative is the only way to go in order to be able to achieve the needed reforms, so be it. Let's do it. We must recognize that it takes more effort on our part, however, than merely securing signatures on a petition. It will not only require a basic commitment of time from all of us, but such an endeavor will also require money.

> **"I have moved our agenda forward, and I believe this society is more alive now than it has ever been."**

Are we prepared to go the full course, or do we die?

The leaders who will follow me are honorable and trustworthy. They will listen to you and follow your bidding. You don't need to go outside of our organization and form destructive splinter groups.

Together we are a power block, but separately we are simply single voices crying in the wilderness.

No apologies for SMLT

Six months ago I really thought we were on the verge of a great victory over the malpractice noose. The State Medical Liability Trust with the floating cap, as it was postulated by Robben Fleming, was a ingenious idea and would have been the envy of the entire nation.

There is no other plan quite like it anywhere. However, many of you expressed problems with the proposed solution, and we listened. We understood that a significant number of you would be unable to benefit from a State Medical Liability Trust because the rates for required basic insurance are presently not only excessive but obscene as well.

I do not apologize for our efforts in trying to implement such a program. Your concerns are legitimate, and we acted accordingly. It would appear now that the idea of such a trust is remote at best, certainly dead in its present form.

I have not accomplished what I so fervently hoped for and worked for.

However, I think I have moved our agenda forward, and I believe this society is more alive

Continued on page 368

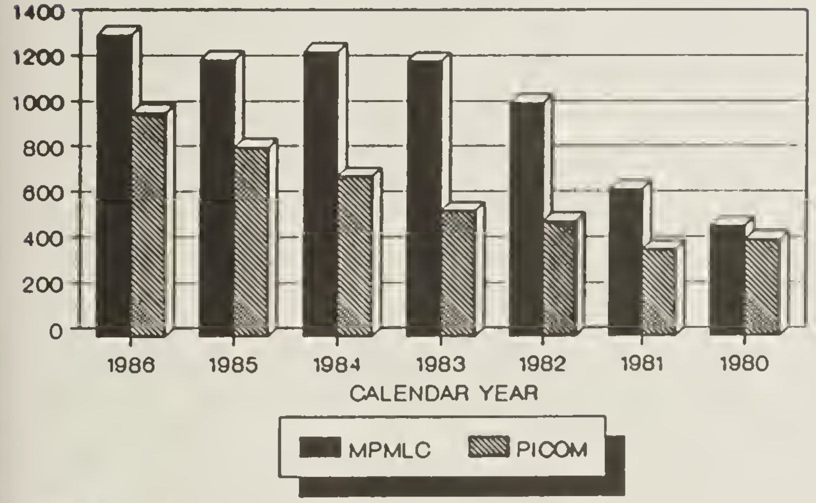
MICHIGAN STATE MEDICAL SOCIETY

Physician's FILE

This is the first in a series of biannual reports about socioeconomic aspects of medicine and medical practice. This issue focuses on three topics: professional liability trends; health care expenditures; and facts about the frequency and cost of AIDS. Future editions will contain information on the supply of physicians, practice expenses, hospital statistics and changes in delivery systems. We hope you will find this potpourri of information interesting and useful. This report was prepared by the MSMS Department of Medical Economics and Health Care Delivery.

Professional Liability

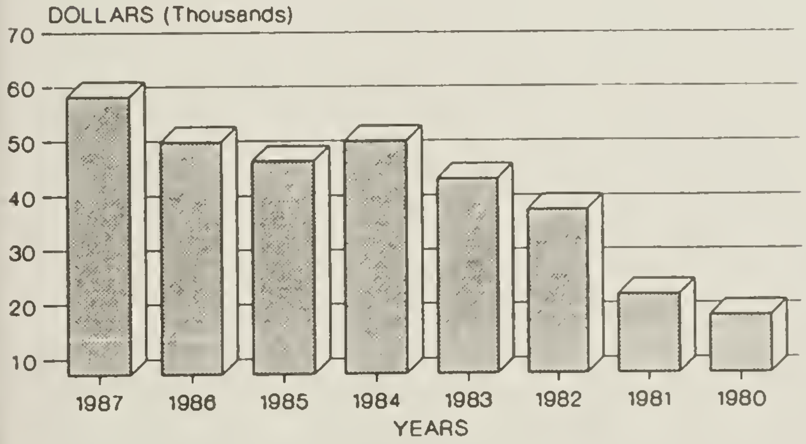
MPMLC & PICOM REPORTED CASES*
CALENDAR YEARS 1980-1986



*Includes lawsuits and other claims

Michigan's two major carriers of malpractice insurance for physicians — Michigan Physicians Mutual Liability Company (MPMLC) and Physicians Insurance Company of Michigan (PICOM) — have experienced an increase from 910 claims filed in 1980 to 2314 filed in 1986.

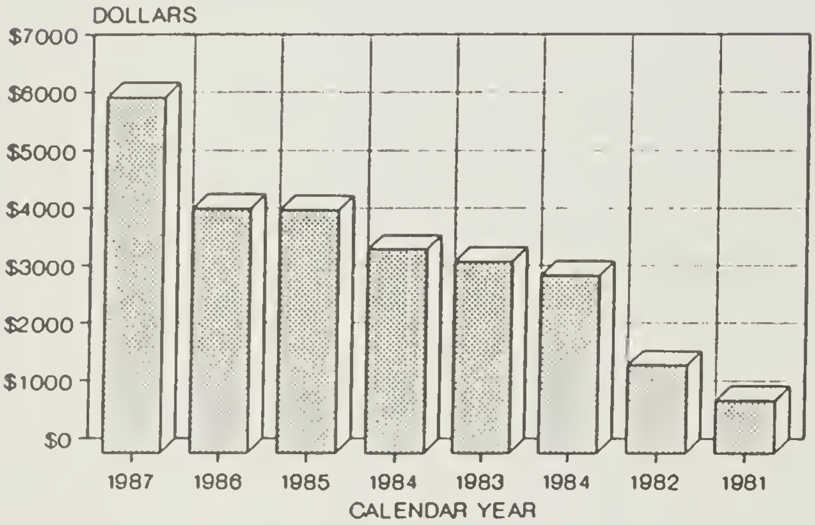
AVERAGE INDEMNITY PAYMENT
PER CLOSED CASE* W/INDEMNITY
FOR MICHIGAN



PRODUCED BY: MICHIGAN STATE MEDICAL SOCIETY
*Includes lawsuits and other claims

The average indemnity payment (excludes defense costs) made by Michigan's largest insurers, for cases in which some payment was made, increased from $16,000 per closed claim in 1980 to over $60,000 in 1987. Average defense costs in these cases rose from $3,700 in 1980 to $15,500 in 1987.

MPMLC & PICOM AVERAGE DEFENSE
COST PER CLOSED CASE*
WITHOUT INDEMNITY, 1980-1987



Although a majority (around 60 percent) of claims are settled with no payments being made, these cases have significant expenses. Costs have risen from $920 on average in 1981 to $6,100 in 1987 for Michigan's two largest insurers.

1987 Annual Malpractice Rates For Michigan & Adjacent States For Selected Specialties $100,000/300,000 Occurrence Policies*

	MICHIGAN	INDIANA	OHIO	ILLINOIS
NON-METRO AREAS				
GP — no Surg.	$ 4,820	$ 1,334	$ 2,948	$ 5,823
GP — w/Surg.	$13,585	$ 3,201	$ 9,256	$ 8,787
General Surg.	$18,490	$ 7,003	$15,328	$18,680
OB/GYN	$31,172	$11,340	$18,570	$27,581
METRO AREAS				
	MICHIGAN	INDIANA	OHIO	ILLINOIS
GP — no Surg.	$ 8,033	$ 1,695	$ 2,948	$ 7,060
GP — w/Surg.	$22,642	$ 4,068	$ 9,256	$10,761
General Surg.	$30,187	$ 8,888	$15,328	$23,126
OB/GYN	$51,952	$14,408	$18,570	$34,255

*Illinois figures based on $100,000/300,000 mature Claims Made Policy.

Indiana figures include a 125 percent premium surcharge on base rates, allowing physicians to participate in a Patient Compensation Fund which places a cap on liability awards.

Michigan's malpractice rates are higher than those typical in neighboring states. A Michigan OB/GYN pays an average of $37,544 per year more than Indiana counterparts. A general surgeon in Michigan pays $7,601 per year more than a surgeon in Illinois, the next highest state.

Most physicians pay more in premiums than the amounts listed at left, since the majority have higher policy maximums than the $100,000/300,000 used for this comparison. This level of coverage was used since it was readily available from all states surveyed. Most Michigan physicians have $200,000/600,000 policy limits.

Health Care Expenditures

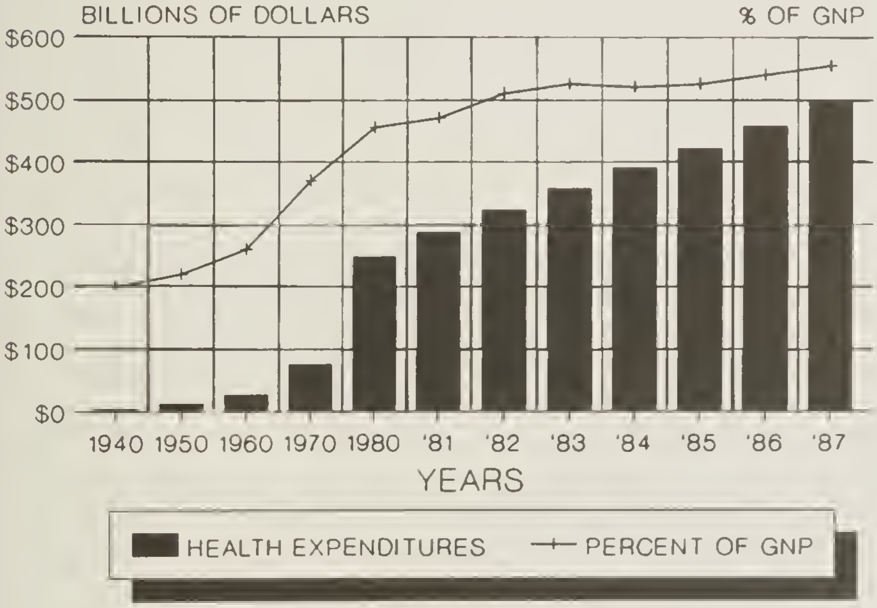
Michigan Health Care Expenditures

Michigan's per capita health care expenditures are above national expenditures:

	MICHIGAN	U.S.A.	% DIFF.
1972	388.2	366.7	6%
1980	1101.6	933.7	8%
1986	1638.5	1504.3	9%

National health care expenditures are accounting for increasing portions of the Gross National Product (GNP):

NATIONAL HEALTH CARE EXPENDITURES
UNITED STATES, 1940 TO 1987



Percentage of All Health Care Expenditures Going to Physicians and Hospitals

	HOSPITAL		PHYSICIAN	
	U.S.	MI	U.S.	MI
1972	43.7%	43.7%	21.4%	21.9%
1980	46.2	47.0	21.3	21.4
1985	44.9	47.7	22.5	21.1

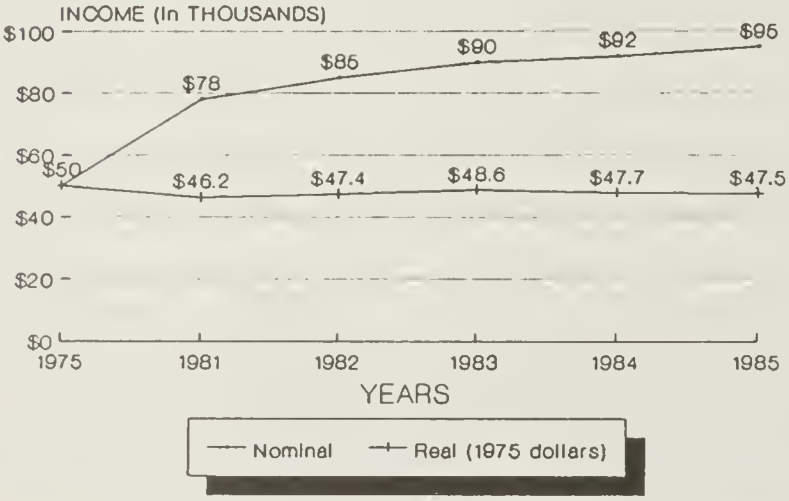
Nationally, hospital care continues to consume the largest portion of total health care expenditures in all categories. The percentage of health care dollars going to physicians has remained fairly constant over time, but is falling modestly in Michigan.

Medicare Enrollment And Benefits Paid 1975 To 1986 (All dollars reported in 1986 dollars)

YEAR	Medicare Enrollment	Enrollment % Increase	Per Capita Benefits Paid	Benefits Paid % Increase	Total Federal Medicare Expenditures
1975	25.0 mil	14%	$ 984	108%	$24.6 bil
1980	28.5 mil	11%	2,046	17%	58.3 bil
1986	31.7 mil		2,397		76.0 bil

When deflated by the CPI, the median income for physicians in the U.S. has dropped slightly over the period from 1975 to 1985.

Nominal & Real Median U.S. Physician Net Income: 1975 To 1985



AIDS Profile

The five leading states for reported AIDS cases include: New York (25.7 percent), California (22.3 percent), Florida (7.1 percent), Texas (7.1 percent), New Jersey (6.4 percent). Michigan cases represent 1.4 percent of all U.S. diagnoses.

AIDS Cases By Year Of Diagnosis For U.S., Michigan, & Detroit

	U.S.	MICHIGAN	DETROIT
1984	5,704	52	28
1985	10,121	106	50
1986	15,148	161	78
1987	15,661	234	110

The average rate of hospital admission for a Michigan AIDS case is 2.6 times. Each stay has averaged 17.29 days in length.

Since 1984, Medicaid has been the payment source for nearly one-half of AIDS hospital admissions. Blue Cross and commercial carriers follow with 37 percent, and Medicare and HMOs pay for 3 percent.

The average hospital cost per AIDS case in Michigan is $41,104, at an average rate of $918 per inpatient day.

Total Michigan inpatient hospital costs for AIDS care increased from $14,533 in 1981 to $3.8 million in 1986.

NEED PHYSICIANS?

CONTACT:
Physician Placement Service
Michigan Health Council
1305 Abbott Road, Suite 106
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The Michigan Health Council assists communities in their efforts to recruit physicians to practice in their area.

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- Cytology-DNA/ploidy
- Electron Microscopy
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Specimen Collection Available at:

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- Brighton Health Care Center
- Chelsea Family Practice
- Taubman Blood Drawing Stations

Kenneth D. McClatchey, M.D., Director

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Medical Science Building I
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Ann Arbor, MI 48109-0602

Local 313-936-2598
Michigan 1-800-862-7284
Outside Michigan 1-800-537-7284

MSMS enters exclusive contract with Delta Dental Plan

Beginning May 15, MSMS and Delta Dental Plan of Michigan began offering you the opportunity to enroll in a dental benefits plan designed specifically for MSMS members.

MSMS members and their staff, as well as spouses and dependent children of both members and staff, are eligible. This dental program is available on a group basis, exclusively through the Michigan State Medical Society.

Dental benefits, unlike medical, life and other coverage, are offered only to groups because of the risk of adverse selection involved. In other words, if a dental plan was offered on an individual basis, only those people needing extensive care would tend to purchase the benefit. This would raise the cost of coverage to an unacceptable level for most people.

But, with the sponsorship of MSMS, members can be "pooled" and the benefit made available to very small groups and to individuals.

Important features

As mentioned earlier, this program is administered by Delta Dental Plan of Michigan. Delta is the leading dental carrier in the state, with plans covering almost 2 million people. As one of the oldest dental benefit plans, Delta pioneered a number of features that help protect subscribers and keep costs down. These include:

- *Contracting dentists*—Over 90 percent of the actively practicing dentists in Michigan have signed contracting agreements with Delta. This means that the contracting dentist will accept Delta's determination of payment as the full fee for services rendered. This is important because it means that you will pay only your co-payment or other obligations specified by the MSMS contract, if you go to a contracting dentist.

In addition, Delta's contracting agreements require that the dentists' usual fees (the lowest fees regularly charged and received) be filed with Delta. These fees are used as the basis of the Usual, Customary and Reasonable fee system. Contracting dentists receive payment based on their own usual fees, up to a ceiling established as customary for dentists of similar training in their geographical area.

If the contracting dentist's usual fee is higher than the fee determined to be customary for the case in question, he/she agrees not to charge the difference to the Delta subscriber. This can save you money.

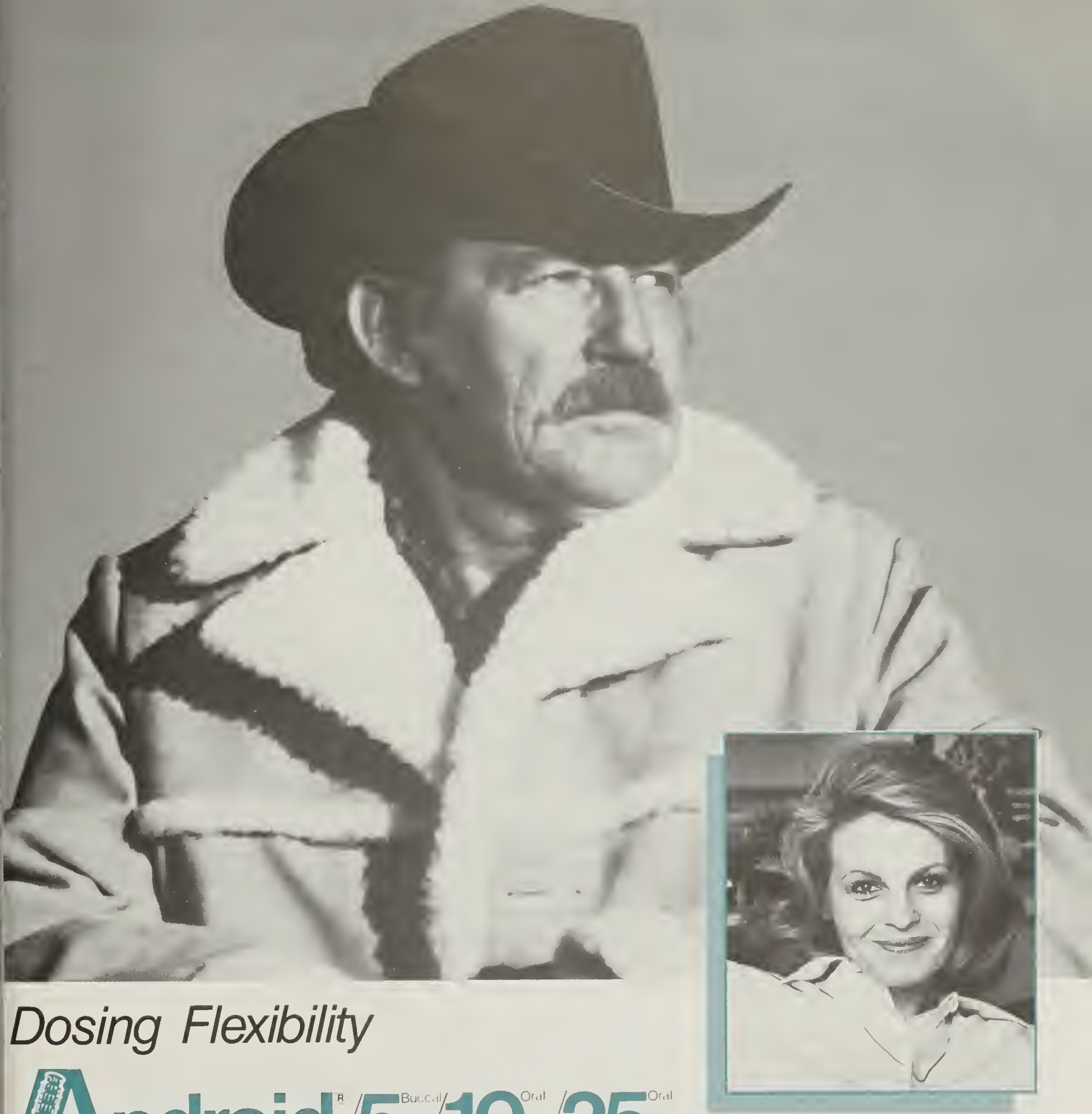
- *Predetermination*—This is a feature that allows you to find out, in advance, what your dental costs will be for a specific treatment plan. If your dental care will cost more than $200, Delta asks that your dentist submit the treatment plan before service rendered. Delta then determines what your co-payment (if any) will be for this care. This enables you to make any necessary financial arrangements with your dentist before starting treatment and eliminates any unexpected charges.
- ***Review of treatment received***—With the cooperation of the Michigan Dental Association, Delta conducts reviews of the dental services received by program subscribers. A Delta representative and a Michigan Dental Association consultant regularly travel to various locations throughout the state and examine a random sample of subscribers. In addition, if any subscriber is concerned about the dental treatment received, a review can be conducted on request. The purpose of these reviews is to ensure that the dental treatment charged to Delta has been provided, that it has been reported accurately and that it is up to generally accepted standards of dental practice.

Services covered

The following defines the services covered by the MSMS-sponsored dental program and the percentage of coverage of the contracting dentist's usual/customary fee for each category:

- Diagnostic—Includes oral examinations and emergency palliative treatment. **Delta pays 100 percent.** You pay nothing.
- Preventive—Includes prophylaxis and topical application of fluoride solution. **Delta pays 100 percent.** You pay nothing.

Continued on page 366



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- **Radiographs**—As required, and in connection with the diagnosis of a specific condition requiring treatment. **Delta pays 100 percent**. You pay nothing.
- **Oral Surgery**—Includes extractions and other oral surgery procedures usually employed by a dentist, including pre- and postoperative care. **Delta pays 50 percent**. You pay 50 percent.
- **Restorative**—Includes amalgams (fillings), synthetic porcelain, plastic restorations, relines and repairs to prosthetic appliances. Gold restorations, crowns and jackets may be used, but only when the teeth can't be restored with another filling material. **Delta pays 50 percent**. You pay 50 percent.
- **Periodontics**—Procedures usually employed by a dentist to treat diseases of the gums and supporting structures of the teeth. **Delta pays 50 percent**. You pay 50 percent.
- **Endodontics**—Procedures usually employed by a dentist for the treatment of non-vital teeth. **Delta pays 50 percent**. You pay 50 percent.
- **Prosthetics**—Includes procedures for the construction of bridges, partial and complete dentures. **Delta pays 50 percent**. You pay 50 percent.
- **Orthodontics**—Treatment and procedures required for the correction of malposed teeth. **Delta pays 50 percent**. You pay 50 percent.

Benefit maximums

The maximum dollar amount that this plan pays during each contract year, for each covered person, is $1,000.

For orthodontic care, the plan pays a *lifetime* maximum of $1,000 for each eligible person.

Other points

Exclusions and limitations—Although this program covers a wide range of services, there are some services that are not covered and others that have time and age limitations. For example, prophylaxes are covered, but no more than twice in a 12-month period.

These kinds of exclusions and limitations help protect your group from unnecessary or inappropriate expenses. You'll find a complete list of exclusions and limitations in the benefit booklet you receive after you enroll.

Coordination of benefits—Delta coordinates benefits with other dental benefit carriers. However, the combined benefits can't exceed the dentist's fee. You will need to supply the dentist's office with the following information to apply for coordination of benefits: name, birthdate and social security number of your spouse, the name and address of his/her employer and your spouse's group plan name and number.

Optional treatment—If you select a more expensive treatment than Delta determines is necessary according to accepted standards of dental practice, Delta will base its payment on the fee for the customary service and you'll be responsible for the rest. For example if a tooth can be satisfactorily restored with an amalgam filling, but you choose to have a gold restoration, you can have the tooth restored with gold, but Delta will make payment on the amalgam filling. This amount can be put toward the cost of gold and you'll be responsible for any difference in the cost.

How to enroll

You received a mailing in mid-May which outlined the dental benefit program and showed your costs. Enrollment cards were included for each eligible person in your office. If you haven't already enrolled, all you and your staff need to do is fill out those cards and return them to MSMS.

Those eligible for coverage are all MSMS members, their spouses and dependent children, and staff personnel of MSMS members, along with their spouses and dependent children.

The enrollment period runs from May 15 to June 30, 1988. You'll want to sign up now, because the next open enrollment period will be May 1989.

Questions?

If you have any questions regarding this plan, please feel free to call Michael Kelly at (517) 337-1351, ext 62. □

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- Offer available for new recreation vehicles financed through June 30, 1988

Additional rates and terms are available for motor homes, recreation vehicles and boats. Just contact the credit union loan department for details.

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Vacation Loans

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Commemorating 75 Years of Life!
American Cancer Society
Join us

ADDRESS/Continued

now than it has ever been. That gives me a great deal of satisfaction if I played a role in making it happen. I believe the next major effort by this organization will finally see success if we have the faith to pursue success.

I hope that you will give those leaders who follow me the tools to negotiate for a better system. Our patients, our children and our grandchildren deserve the very best. We need to get back to practicing medicine—not law. We have patients who need us. I wish all of you and this wonderful medical society continued strength and success in the future.

Thank you. ☐

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PRACTICE MANAGEMENT

Be efficient, stay on time

By John Anthony

Editor's note: This is the first in a new series of articles on practice management. Future topics include cash control, personnel management, computer use in the physician-office setting, and competitive business strategies. These articles are being presented as a service of Physician Service Group Inc., an MSMS subsidiary. For more information on this or future practice management articles, contact Amy Fistler at MSMS.

The author is a consultant to Physician Service Group, Inc.

The key to running an efficient medical practice is how well the office staff and physician handle incoming and outgoing phone calls.

Incoming phone triage is the single most important factor in the smooth operation of a medical practice. This one activity can cause unnecessary, and often significant, delays in seeing scheduled patients, confusion at the front desk, and a general state of inefficiency in the operation of the physician's practice.

Although most physicians feel that they are capable of being worldclass sprinters, that often is not the case. When a practitioner is interrupted in his or her movement from exam room to exam room, a period of confusion results and many moments of time may be wasted.

The usual reason for interruption is to answer calls from patients who are seeking legitimate information about theirs, or a relative's care. Since these in-

Continued on next page

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Lester Weiss, M.D., Director
Jacquelyn Roberson, M.D.
Miriam G. Forsythe, M.S.
Patricia Lieder, R.N.
Jo-Ann Caissie, R.N.
Suzanne L. Diment, R.N.

Metric Medical Labs and the Medical Genetics and Birth Defects Center at Henry Ford Hospital are pleased to announce a joint program of alpha-fetoprotein testing for detection of neural tube defects and Down Syndrome.

Further information on this program is available through Metric Medical Labs and Henry Ford Hospital.

coming calls are made at the convenience of the patient, they may occur at times not convenient for the practitioner or staff. Most often the practitioner must refer to a medical chart and/or results of lab or x-rays to answer the patient's question. Since these usually are not readily available to the practitioner when a patient calls, the physician must instruct his staff to retrieve these documents. This takes away from the smooth flow of the assistants' work patterns.

Solving the problems

A telephone disposition worksheet should be created that defines the reasons or circumstances to interrupt the practitioner during the exam day. Also, criteria should be established to define when it is necessary for the practitioner to return a call to a patient.

Many times the incoming call can be handled as easily by other personnel as by the physician. If the doctor must speak with a patient, the staff should indicate the approximate time that the practitioner will be calling back.

The physician's staff should set aside time in both the morning and afternoon to return patients' calls. Patients should be told of the time, and should be given instructions to stay off the phone during this period of time. Also, it is important that the staff make certain that they get the number where the patient will be at that time.

The practitioner should have all of the return messages numbered and attached to the appropriate medical chart and test results documents. All phone calls should be denoted in the medical chart. This is to document the instructions given to patients as well as to keep track of the patients who are seeking their health care over the telephone instead of coming in to be examined.

There are telephones that can be pre-programmed with the patient's numbers. The physician can simply touch the number that is on the recall message and it will automatically dial the patient's phone as pre-programmed by the staff at an earlier time in the day.

A good appointment schedule is the next step

In order to maintain a schedule of patients, it is vital to understand the difference between long, medium and short visits. The actual time spent on these different types of visits should be observed, calculated, and used in the establishment of an appointment schedule. Practitioners in a multiple practice have different ways of seeing patients and each one should have their own appointment schedule that reflects the manner and time in which they see patients.

Before embarking upon the establishment of an appointment calendar, you must first keep track of the number of walk-ins, no shows and cancellations to the practice. A several-week period of time should be examined. Keep track of the various types of patients that can be significant in the disruption of the practice day. For example, if on average there are four no shows and seven walk-ins on a Monday afternoon, then it is important to allow for three open spaces in the appointment schedule for that period of time.

In this age of consumerism, it is important that we respect our patient's time, and see them as close to the prearranged time as possible. Patients are becoming very intolerant of having to wait great lengths of time at the physician's office. Look at the successes of the urgent care practices which pride themselves on not keeping the patient waiting.

One thing that should be considered in the scheduling of various types of appointments during the exam day is to have the longest exam be the first exam of that morning or that afternoon. Since this exam normally has additional ancillary personnel, it is possible to start the exam before the practitioner arrives.

If you find that you are going to be late for your afternoon schedule of patients and you have scheduled four patients per hour for five consecutive hours, call ahead to your staff and have them indicate to your first group

Continued on page 372

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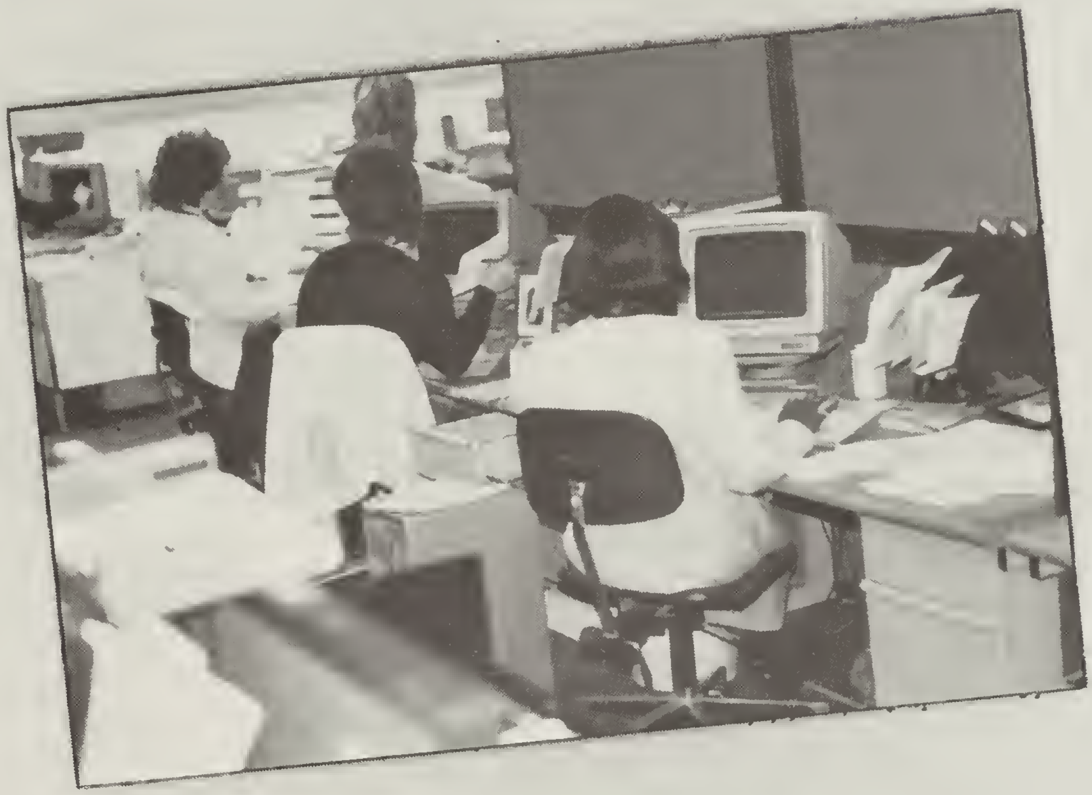

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IN MY OPINION/Continued

than it pays the injured parties.

Having gone through the 1974-75 liability "crisis" as chairman of the Committee on State Legislation and Regulations, and the present "crisis" as MSMS president-elect, president and past-president, I know that we will get no help from the legislature as long as they have the same misperceptions as the rest of the public. Maybe the fact that they are paying to educate medical students and residents who are leaving will have an effect.

Legislators, not only are you perpetuating a system that needs change, but also you are subsidizing other states by exporting our young physicians. Fix the system! ☐

"When I suggested we seek a second opinion — I didn't mean yours!"

EFFICIENT/Continued

of patients that you have been detained. Give them the option of coming back at the end of the exam day or being rescheduled for another day. This way instead of seeing all of your patients an hour behind for the entire afternoon, you will see the patients that are scheduled at 2:00 p.m. on time.

Schedule all patient visits

Schedule all patient visits, even the "short" ones that hopefully do not require a physician. A practitioner who allows a patient to stop in when it is convenient (for the patient) is asking for problems. If a patient comes unannounced for a blood pressure check, all of your planning and systems are impacted.

Since you are not going to check your patient's blood pressure in the waiting room, you have to place them in an exam room where a full office visit charge patient could be. Your nurse or aide takes the pressure and you guessed it, it's off the meter. Now, the doctor has to be called in to determine what to do next. This simple little visit has affected all of your systems and most of your personnel.

And since it wasn't scheduled, you can't handle it efficiently.

Resist the temptation of telling a patient to just "drop in." It creates an interruption that is hard to overcome. ☐

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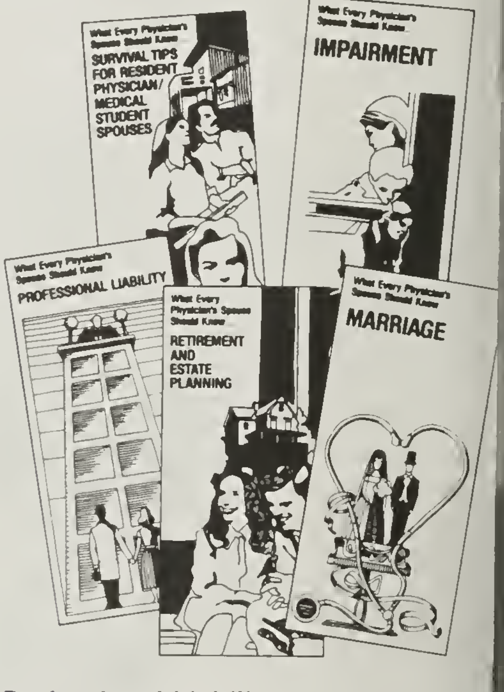
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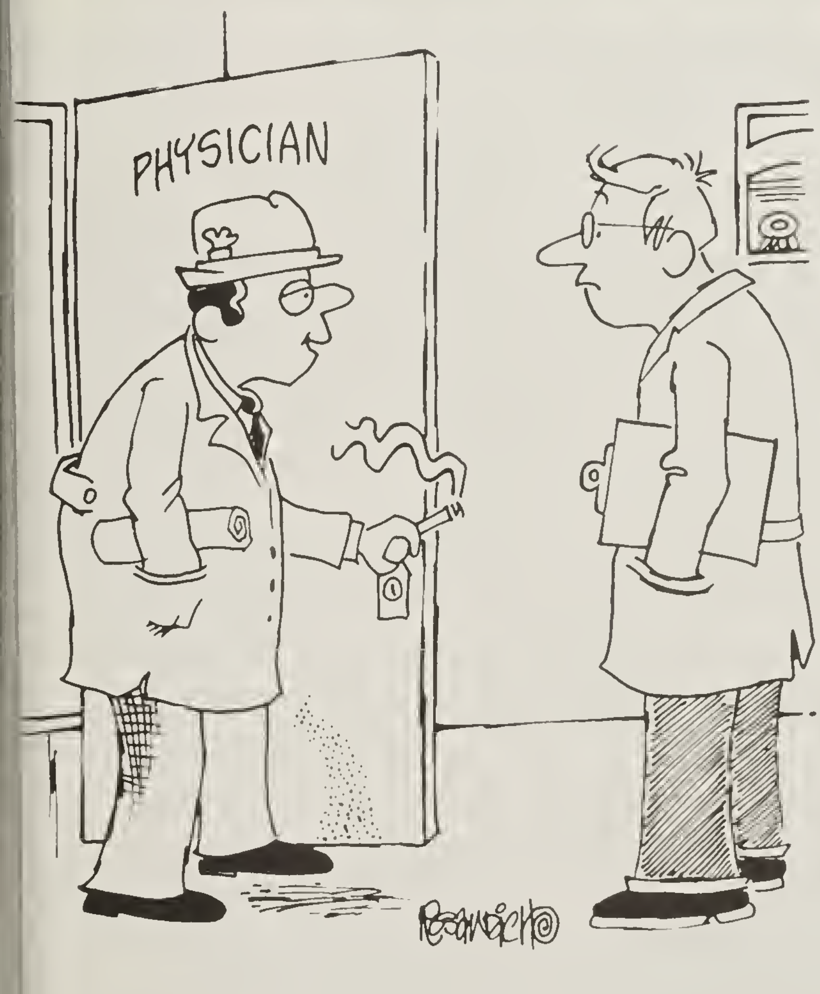

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References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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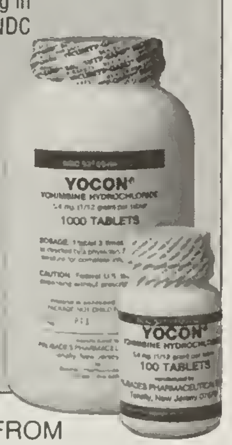

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Several resident-physicians plan to leave state, MSMS survey shows

Six of every 10 physicians currently in a residency training program plan to leave Michigan once their education is completed, according to the results of a recent MSMS survey.

Another 10 percent are uncertain if they will stay in Michigan. Only 30 percent of the physicians-in-training plan to stay.

High costs of liability insurance and the malpractice climate in Michigan are the two top reasons these young physicians plan leave, the survey found.

"If you don't start to take care of this problem now, Michigan patients will begin to lose access to physicians, particularly those in the high-risk specialties," said Frederick W. Bryant, MD, of Royal Oak, president of the 11,000-member MSMS.

In specialty areas, 63 percent of the obstetricians/gynecologists; 79 percent of the emergency room physicians; and 92 percent of the orthopaedic surgeons plan to leave Michigan at the end of their residency program.

Michigan, at 1.9 physicians per 1,000 people, already is below the national average of 2.2 physicians per 1,000 people, said MSMS Manager of Medical Economics, Thomas White, who conducted the survey.

Residency programs are two to six years of specialized training in a hospital setting following completion of medical school.

Results have been tabulated from 318 responses to a survey mailed in March to 76 state residency programs. There are currently an estimated 2,000 physicians in residency training in Michigan.

Only in family practice do a majority of residents, 62 percent, plan to stay in Michigan.

The number of residents who plan to leave Michigan correlates directly to the cost of medical liability (malpractice) insurance they would be required to pay and the frequency of lawsuits against the specialty.

While a colleague in an Indiana city pays $14,408 a year for a $100,000 policy, an obstetrician/gynecologist in Detroit would pay $51,952. A Michigan obstetrician, however, seldom buys a policy as low as $100,000; the standard in Michigan is $200,000 coverage for which a Detroit obstetrician pays approximately $68,274 per year.

The MSMS survey results are similar to, but higher than, earlier surveys of residents conducted by other health care organizations.

In the years 1984-86, surveys conducted by the Michigan Council on Graduate Medical Education showed 43 to 44 percent of physician residents planned to leave Michigan. In 1987, a survey of residents by the Michigan Health Council showed 56 percent plan to leave.

The increase in the number of residents leaving reflects the increase in lawsuits filed against Michigan doctors over the past few years.

In 1980, the two largest medical liability insurance companies reported a total of 925 suits against doctors. In 1986, they reported 2,345.

The Michigan State Medical Society is urging Govenor James J. Blanchard to appoint a special task force to study more equitable alternatives to the current court system for settling medical liability claims as recommended by his fact-finder, Robben Fleming, the former, and currently interim, president at the University of Michigan.

Heart attack victims may return home after 3 days, U-M study shows

Advanced treatments have made it possible for patients to go home just three days after a heart attack, a University of Michigan Medical Center study has shown.

The study, reported recently in the *New England Journal of Medicine*, indicates that for some patients the average eight-to-10-day hospital stay after a heart attack can safely be cut by two-thirds.

The study compared heart attack patients discharged three days after admission with those released after a conventional hospital stay, and found them equally healthy after six months.

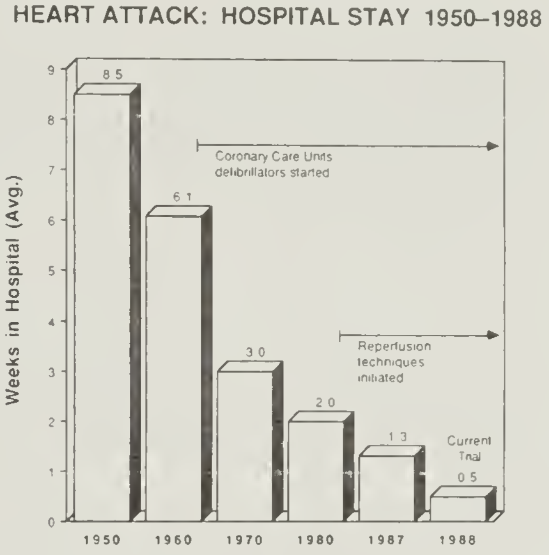
It is the shortest heart attack hospitalization ever studied.

Early discharge resulted in a 30 percent reduction in total hospital charges—more than $5,000 per patient in the trial at the U-M Medical Center.

An unexpected benefit was that patients in the three-day release group felt well enough to return to work two-and-a-half weeks earlier than those discharged after a conventional tay.

Artery-opening treatments like issue plasminogen activator (t-PA) and angioplasty that limit damage to the heart were closely linked to early discharge, said Eric J. Topol, MD, principal investigator in the study.

"Our study proved early discharge is feasible, safe and cost-effective for patients with no complications and a normal exercise test. The shortened stay was not accompanied by any subsequent heart damage or increased need for hospital readmission,"



Courtesy of University of Michigan Medical Center

Continued on page 377

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Residual Coronary Artery Stenosis after Thrombolytic Therapy LOWELL F SATLER, MD et al

Assessment of Aortic Regurgitation by Doppler Ultrasound PAUL A GRAYBURN, MD et al

Embolic Risk Due to Left Ventricular Thrombi JOHN R STRATTON, MD

Hemodynamic Effects of Diltiazem in Chronic Heart Failure DANIEL L KULICK, MD, et al

Cardiovascular Reserve in Idiopathic Dilated Cardiomyopathy RICKY D LATHAM, MD, et al

Overview • Coronary Angioplasty: Evolving Applications GEORGE W VETROVEC, MD

*Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.

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1986
Summary of Financial Conditions and Operating Results Health Maintenance Organizations (HMOs)

Only seven out of 24 HMOs operating in Michigan showed a net profit for 1986, according to the latest data released by the Michigan Insurance Bureau. Total losses for the year surpassed $11 million. 1987 figures will probably show less profitability, the Bureau predicts. *Michigan Medicine* will feature more data on HMOs as it becomes available.

(Dollar amounts in thousands)

	Total Revenue	Benefits Provided	Net Profit	Enrollment
Butterworth HMO	168	121	(214)	1,300
Comprehensive Health Services of Detroit	38,872	32,912	(1,473)	48,045
Grand Valley Health Plan	10,369	8,031	350	17,289
Greater Flint HMO	29,435	27,821	(1,484)	33,045
Great Lakes Health Care	6,820	6,200	(843)	10,516
Group Health Plan of Michigan	20,277	19,095	(2,053)	46,500
Group Health Service of Michigan	32,105	27,738	1,091	42,256
Health Alliance Plan of Michigan	174,695	156,376	8,417	207,436
Health Care Network	143,481	137,909	(8,595)	174,246
Health Central	50,277	46,152	(544)	55,151
Health Circle	31,408	28,169	(766)	43,511
Health Plus of MI	117,534	109,951	(4,144)	127,586
HMO America — MI	869	905	(1,330)	1,752
HMO West	5,523	5,322	(2,031)	13,287
Maxicare's Independence Health Plan	120,305	98,953	3,413	147,592
Lakeshore HMO	1,953	1,721	(377)	4,872
M-Care	637	1,000	(1,926)	5,107
McAuley Health Plan	21,965	18,905	(448)	33,259
Mercy Alternative HMO	1	0	1	0
Michigan HMO Plans	43,703	36,088	(780)	53,251
Physicians Health Plan	71,434	57,968	1,909	130,257
Preferred Health Plan	23,356	21,342	(302)	18,603
Total Health Care	14,583	11,040	734	17,859
West Michigan Health Care Network	54,800	47,397	303	82,708
TOTAL	1,014,570	901,116	(11,092)	1,315,428

*SOURCE: Michigan Insurance Bureau
PRODUCED BY: Michigan State Medical Society

EWSFRONTS/Continued

opol stated.

However, more extensive studes involving more patients are eeded to confirm the safety of arly release, he added.

Frequent antacid users prevalent, says Gallup

More than 61 million Ameri-ans—44 percent of the adult population—suffer heartburn monthly; and one out of eight (or 18 million adults) take indigestion aids (including antacids) two or more times a week, according to "Heartburn Across America," a nationwide Gallup survey of 1,000 adults released recently.

"Frequent users of indigestion aids—those who take them two or more times a week—are more often age 50 years and older," said Neil Upmeyer, research director of the Gallup Organization at a press briefing. One out of every five adults 50 years or over (22 percent) is a frequent user, compared to one in ten of the younger age group (9 percent).

Although an overwhelming majority (86 percent) of adults polled consider physicians a reliable source of information on heartburn, most chronic users of indigestion aids (59 percent) said they did not plan to consult physicians about heartburn. ☐

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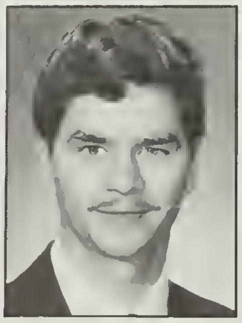
Carioni

Voorhees

Charles R. Schmitter, Jr., MD, Ann Arbor, was installed recently as president of the Michigan Society of Anesthesiologists at the group's annual meeting in Novi. . . . **Norman Rosenzweig, MD**, is the new acting chairman of the department of psychiatry, at the Wayne State University School of Medicine. Doctor Rosenzweig joined the WSU School of Medicine faculty in 1961, and became a professor of psychiatry in 1973. . . . **Juan C. Carioni, MD**, Troy, was installed as president of the Michigan Society of Internal Medicine at the group's annual meeting in Traverse City. The meeting, held in conjunction with the American College of Physicians-Michigan Chapter, is one of the largest regional gatherings of internists in the country with 400-500 attending. . . . **John J. Voorhees, MD**, professor and chairman of the department of dermatology at the University of Michigan Medical School, has been elected president of the Dermatology Foundation for 1988. . . . **Michael Seidman, MD**, Detroit, a resident physician in the department of otolaryngology at Henry Ford Hospital, has been elected a Board member of Self Help For The Hard of Hearing (SHHH), located in Bethesda, Maryland. . . . **Donald Williams, MD**, professor and chairperson, department of psychiatry, at Michigan State University, has been invited by Govenor James Blanchard to serve on the planning committee of the 1988 Michigan-sponsored national conferences on "Trends and Issues: Mental Health Services in the 1990's," to be held in October. . . . **Karl J. Edelmann MD**, Ann Arbor, a second year resident at the University of Michigan Family Practice Program has been elected chairman of the Michigan Academy of Family Physicians Residents Committee for 1988-89. . . . **Steven A. Yarows, MD**, a member of the Chelsea Community Hospital medical staff since 1981, has been appointed medical director of the Hospital's Intensive Care/Cardiac Care Unit. . . . **Richard R. Neubig, MD, PhD**, Ann Arbor, assistant professor of pharmacology and internal medicine at the University of Michigan Medical School, has received an Established Investigatorship award from the American Heart Association. The five-year award, which will begin July 1, provides salary support for physicians and scientists to develop independent research careers in academic medicine and biology. . . . **Richard H. Schiappacasse, MD**, Shelby Township, has been appointed medical director of infection control for St. Joseph's Hospital Centers. He will assist the hospital in formulating infection control policies and the pharmacy in streamlining therapeutic modalities. . . . **Evelyn Golden, MD**, Flint, was honored recently as the 1987 "Health Advocate of the Year" by the American Lung Association of Genesee Valley. . . . **Kent Hassan, MD**, Buchanan, a Buchanan family practitioner, retired recently from his practice after 36 years. . . . **Cheryl Huey, MD**, Ann Arbor, has received the Physician's Recognition Award from the American Medical Association. Dr. Huey has fulfilled the requirements for this award in continuing medical education by attending post-graduate courses in the latest developments of eye care. ☐

Williams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	Severe/Complicated	750 mg
Urinary Tract*	Mild/Moderate	250 mg
	Severe/Complicated	500 mg
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg

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INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below

Lower Respiratory Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Pseudomonas aeruginosa. Haemophilus influenzae, Haemophilus parainfluenzae,* and *Streptococcus pneumoniae.*

Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin Therapy with Cipro® may be initiated before results of these tests are known, once results become available appropriate therapy should be continued As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN The oral administration of ciprofloxacin caused lameness in immature dogs Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION)

PRECAUTIONS

General.

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided The recommended daily dose should not be exceeded Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION)

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life This may result in increased risk of theophylline-related adverse reactions If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired, concurrent administration of these agents with ciprofloxacin should be avoided

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum This should be considered if patients are receiving both drugs concomitantly

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential If superinfection occurs during therapy, appropriate measures should be taken

Information for Patients

Patients should be advised that ciprofloxacin may be taken with or without meals The preferred time of dosing is two hours after a meal Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing Ciprofloxacin may cause dizziness or lightheadedness, therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below

- Salmonella/Microsome Test (Negative)
- *E coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed

Pregnancy – Pregnancy Category C

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHRO
IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS)

Nursing Mothers:

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprof
excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk Becau
and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decisi
be made to discontinue nursing or to discontinue the drug, taking into account the importance of the d
mother

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature anim
WARNINGS)

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated During clinical investigation, 2,799 patients received 2,868 c
the drug Adverse events that were considered likely to be drug related occurred in 7.3% of courses
related in 9.2%, and remotely related in 3.0% Ciprofloxacin was discontinued because of an advers
3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervo
(0.4%)

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%),
(2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%)

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below Those
quinolones are italicized

GASTROINTESTINAL *(See above)*, painful oral mucosa, oral candidiasis, dysphagia, intestinal pe
gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM *(See above), dizziness, lightheadedness, insomnia, nightmares,*
tions, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, w
malaise, anorexia, phobia, depersonalization, depression, paresthesia

SKIN/HYPERSENSITIVITY *(See above), pruritus, urticaria, photosensitivity, flushing, fev*
angioedema, edema of the face, neck, lips, conjunctivae or hands, cutaneous candidiasis, hyper
tion, erythema nodosum.

SPECIAL SENSES *blurred vision, disturbed vision, (change in color perception, overbrightness*
decreased visual acuity, diplopia, eye pain, tinnitus, bad taste

MUSCULOSKELETAL *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of

RENAL/UROGENITAL. *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral
vaginitis, acidosis

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina
myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronc
pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the
discontinued, and required no treatment

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were j
investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interac
ciprofloxacin.

Adverse Laboratory Changes Changes in laboratory parameters listed as adverse events without rega
relationship

Hepatic – Elevations of ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LD
serum bilirubin (0.3%)

Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), eleva
platelets (0.1%), pancytopenia (0.1%)

Renal – Elevations of Serum creatinine (1.1%), BUN (0.9%)

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED

Other changes occurring in less than 0.1% of courses were Elevation of serum gammaglutamyl tra
elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin
bleeding diathesis, increase in blood monocytes, and leukocytosis

OVERDOSAGE

Information on overdosage in humans is not available In the event of acute overdosage, the stomach s
emptied by inducing vomiting or by gastric lavage The patient should be carefully observed and given s
treatment Adequate hydration must be maintained In the event of serious toxic reactions from ove
hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularl
function is compromised

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours For pati
complicated infections caused by organisms not highly susceptible, 500 mg may be administered every

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may b
with 500 mg every 12 hours For more severe or complicated infections, a dosage of 750 mg may be giver
hours

The recommended dosage for infectious diarrhea is 500 mg every 12 hours

In patients with renal impairment, some modification of dosage is recommended (SEE DOSA
ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION)

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 5
Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION)

*** Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summ**

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DEATHS

Elvis S. Alford, MD
Belleville

Doctor Alford, a retired Belleville physician and surgeon, died March 27 at age 79. Doctor Alford was graduated from and Wayne State University School of Medicine in 1935. He founded the Belleville Community Hospital Association and was owner/builder of the hospital. Doctor Alford was a retired U.S. Air Force colonel. He was a commanding officer in 1951-52 of a hospital group in Korea, and was awarded the Bronze Star for his work.

Raymond B. Bauer, MD
Grosse Pointe Woods

Doctor Bauer, professor in the neurology department at Wayne State University, died March 23 at the age of 61. He earned his medical degree from Marquette University School of Medicine in 1954.

He was president of the Michigan Parkinson's Foundation, from which he received the Humanitarian Award in 1985. He was president of the Michigan Neurological Association. he co-chaired the International Conference of Cerebro vascular Disease, which resulted in a textbook in 1982. He also was president of the Central Society for Neurological Research.

John W. Bunting, MD
Alpena

Doctor Bunting, a physician and surgeon who served the Alpena Community for nearly 30 years until his retirement in 1966, died April 25 at the age of 76. Prior to establishing an office in Alpena in 1940, Doctor Bunting completed his internship in surgery and pathology in New Orleans and was assigned to the U.S. Marine Hospital in Detroit, where he was a surgeon before becoming resident surgeon at Mount Carmel Hospital in Detroit. In addition to the Coast Guard, he was active in numerous civic and medical organizations throughout his career.

George R. Granger, MD
Grosse Pte. Woods

George Granger, MD, a neurosurgeon and a lifelong resident of the Detroit area, died April 9 at the age of 67. He graduated from Wayne State University Medical School and practiced for over 35 years. He was a veteran of the U.S. Navy, serving during World War II. Doctor Granger was a member of the Wayne County Medical Society and the Harvey Cushing Society.

Barney B. Israel, MD
Studio City, CA

Doctor Israel, a former Detroit physician who lived in Studio City, Calif., since 1982, died March 23 at the age of 87. He was a 1929 graduate of the University of Michigan Medical School and was a general practitioner in Detroit for 53 years. He was a past senior physician for the Detroit Fire Department. A World War II veteran and a member of the Wayne County Medical Society.

Lawrence J. Jasion, MD
Detroit

Doctor Jasion died March 22 at the age of 83. He received his medical degree from Wayne State University School of Medicine in 1933. During World War II, Doctor Jasion served as a Major in general surgery for the U.S. Army Medical Corps. He was a life member of the Disabled American Veterans, the American Medical Society and the Wayne County Medical Society. He received his fifty-year pin from the MSMS in 1983.

Benjamin Juliar, MD
Bloomfield Hills

Doctor Juliar, an internist and gastroenterologist, died April 9 at the age of 79. He was a graduate of Wayne State University School of Medicine. He was involved with the medical evaluation activities at Fisher Medical Centers. He also was medical adviser to administrative law judges, Office of Hearings and Appeals, and the Social Security Administration. Doctor Juliar was attending physician emeritus at Harper and Sinai Hospitals, Mt. Carmel Mercy Hospital, Pontiac and Oakland Hospitals, Dearborn. He was former chief of gastroenterology at Mt. Carmel Mercy Hospital.

Continued on next page

DEATHS/Continued

Mary Finette Marzolf, MD
Ithaca

Doctor Marzolf; first female physician to receive a presidential appointment to the Board of Veterans Appeals, died March 17 at the age of 73. She was buried with full military honors in Ithaca. Doctor Marzolf received her medical degree from the University of Michigan in 1950 and practiced medicine for 10 years in Lansing. A Navy veteran of World War II, she went to Washington in 1962 to serve at the VA headquarters. She was a member of the AMA, the American Academy of Family Practice, and the Ingham County Medical Society.

John R. Rodger, MD
Kalamazoo

Doctor Rodger died April 23 at the age of 83. He received his medical degree at the University of Michigan Medical School. Doctor Rodger was medical director for 40 years at the Meadow Brook Medical Care Facility in Antrim County. A member and past-president of the Northern Michigan Medical Society, he also served as an alternate delegate to the AMA. He was an MSMS delegate for 12 years and served on several MSMS Committees. He also testified for MSMS during early years of the mandatory seatbelt debates. He served on the Michigan Advisory Hospital Council, and was honored by Jamestown College as a "Distinguished Alumnus."

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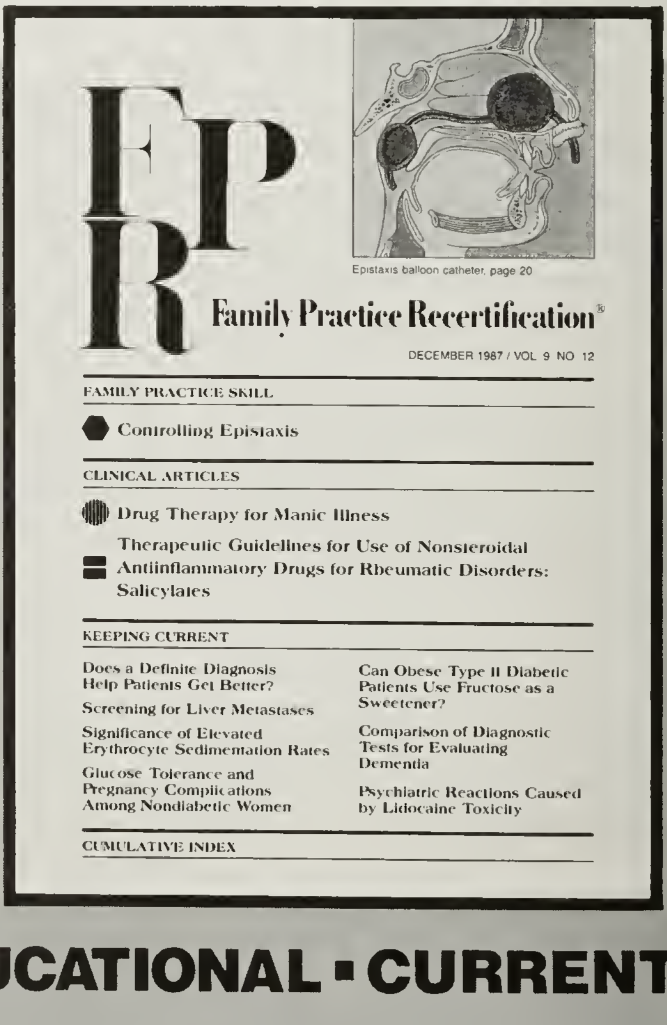
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Epistaxis balloon catheter, page 20

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CLINICAL ARTICLES

Drug Therapy for Manic Illness

Therapeutic Guidelines for Use of Nonsteroidal Antiinflammatory Drugs for Rheumatic Disorders: Salicylates

KEEPING CURRENT

Does a Definite Diagnosis Help Patients Get Better?

Screening for Liver Metastases

Significance of Elevated Erythrocyte Sedimentation Rates

Glucose Tolerance and Pregnancy Complications Among Nondiabetic Women

Can Obese Type II Diabetic Patients Use Fructose as a Sweetener?

Comparison of Diagnostic Tests for Evaluating Dementia

Psychiatric Reactions Caused by Lidocaine Toxicity

CUMULATIVE INDEX

PRACTICAL ▪ CLINICAL ▪ EDUCATIONAL ▪ CURRENT

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Dwight M. Schroeder, MD
East Lansing

Dwight M. Schroeder, MD, died April 8 at the age of 55. He was a graduate of Wayne State University School of Medicine. Doctor Schroeder was as a founder of Leelanau Clinic and was instrumental in the growth of Leelanau Memorial Hospital. From 1974 to 1977 he was a professor at Wayne State University School of Medicine. In 1978 he moved to East Lansing and set up a private practice in Westphalia.

At the time of his death he was working for the State of Michigan as a state agency physician for the Department of Education-Disability Determination.

Steven E. Staryk, MD
Grosse Pointe

Doctor Staryk, a Grosse Pointe native, died April 28 at the age of 68.

He was a graduate of Wayne State University School of Medicine and received the distinguished service award of Alpha Omega Alpha. Doctor Staryk was formerly the head of the anesthesia department at St. John Hospital, Detroit, and Humana Hospital, Cypress, Florida.

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Michael D. Aja, MD — FL/RO
Biederman Cancer Treatment Ctr.
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11311 Grand Oak #22-4
Grand Blanc 48439

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Kalamazoo 49001

D. Basavaraji, MD — N
740 N. Macomb St. #C-19
Monroe 48161

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1025 Kenesaw Dr., SE
E. Grand Rapids 49506

Iam P. Bhisitkul, MD — U
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Niles 49120

Timothy J. Bodnar, MD — EM
Mercy Memorial Hospital
Monroe 48161

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Cadillac 49601

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Oak Park 48237

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Midland 48674

R. Joseph Cranston, DO — OM/FP
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Ada 49301

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LETTERS/Continued

the primary care physicians in the Upper Peninsula and those who attended from northern Wisconsin in that your talk was both enlightening and encouraging.

After visiting with you and enjoying your "fireside chat," there is no question in my mind that you are a true representative of the physicians in the state and are doing your best to help us through a very difficult time. As you mentioned, there are no quick or easy solutions to the liability crisis, but I think it is through efforts of people such as yourself that there is some light at the end of the tunnel, and I think that if we can all work together, we can accomplish true reform.

Once again, thank you on behalf of the physicians of the Superior Chapter of the Michigan Academy of Family Physicians.

Ray S. Koivunen, MD,
President

Family Practitioners & Pediatricians

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I am only in my first year of medical school so it is not too late to change my major. I can knock off a business degree in less than half the time I will spend in medical school. Where is the nearest registration line for accounting 101?

Reinhard Werner Motte
First year student
Wayne State University

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

June

19-24, 24th Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. **Location:** Shanty Creek-Schuss Mountain, Bellaire. **Sponsor:** The University of Michigan Medical School, Department of Family Practice. **Contact:** Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 20 hours Category I Credit.

21, Preventive Oncology. **Location:** Clarion Conference Center, 6810 S. Cedar Street, Lansing. **Sponsor:** Ingham County Medical Society and MSMS Committee for Continuing Medical Education. **Contact:** Samuel M. McMahon, Ingham Medical Center, 401 W. Greenlawn, Lansing 48910 (517)332-2320. **Approved for:** 6 hours Category I Credit.

24-25, Epilepsy Advances: Underlying Mechanism, Diagnostic Modalities, Pharmacological and Surgical Treatment. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** University of Michigan Medical School, Department of Neurology. **Contact:** Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

July

8-11, Fourteenth Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases, Department of Internal Medicine. **Contact:** Betty Phillips, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 11 hours Category 1 Credit.

10-14, Cross Sectional Radiology: MRI, Body CT and Ultrasound. **Location:** Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Henry Ford Hospital, Continuing Medical Education. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3072. **Approved for:** 14 hours Category I Credit.

21-24, Fifteenth Michigan Emergency Medicine Assembly: EMS Concepts 88 and Base Station Symposium. **Location:** Hilton Shanty Creek, Bellaire. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians. **Contact:** Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. **Approved for:** 22 hours Category I Credit.

21-24, Ocular Surgery Update: Newest Techniques, Complications and Management of Ocular Tumors. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Contact:** Christine Jourdain, 412 Eastland Professional Bldg., Harper Woods 48225 (313)839-0311. **Approved for:** 8 hours Category I Credit.

24-27, 2nd Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 13 hours Category I Credit.

25, 42nd Annual Scientific Assembly. **Location:** Grand Traverse Resort, Acme. **Sponsor:** Michigan Academy of Family Physicians. **Contact:** Julie L. Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151. **Approved for:** 25.5 hours Category 1 Credit.

28-29, Coller Penberthy Thirlby Medical Conference. **Location:** Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Munson Medical Center. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City 48684-2386 (616)922-9546. **Approved for:** 13 hours Category 1 Credit.

August

1-6, Pediatric Board Review. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** University of Michigan Medical School, Association of Pediatric Program Directors. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 53 hours Category I Credit.

7-10, Internal Medicine Update. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School 48109-0201 (313) 763-1400. **Approved for:** 11 hours Category I Credit.

12-14, Endocrinology and Diabetes Update. **Location:** Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** University of Michigan Medical School, Division of Endocrinology and Metabolism, Department of Internal Medicine. **Contact:** Karen Brown, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor, 48109-0201 (313)763-1400. **Approved for:** 7 hours Category I Credit.

19-22, Cardiology Update. **Location:** Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 10 hours Category I Credit.

September

15-16, Neonatal Emergencies. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** University of Michigan Medical School, Department of Pediatrics and Communicable Diseases, Section of Newborn Services and Pediatric Pulmonary Medicine. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 14 hours Category I Credit.

15-17, 11th Annual Seminar in Diagnostic Ultrasound. Location: Towsley Ceneter for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Radiology. Contact: Debbie DeSmyther, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 15 hours Category I Credit.

19-20, Update on Pulmonary and Critical Care Medicine. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. Sponsor: University of Michigan Medical School, Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

22-24, 19th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. Sponsor: Michigan State University College of Human Medicine, The Intrernational Federation of Societies for Surgery of the Hand, The Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. Contact: Alfred B. Swanson, MD, Blodgett Professional Building, 1900 Wealthy, S.E., Suite 290, Grand Rapids 49506 (616)774-0440. Approved for: 18 hours Category I Credit.

26-27, Sexual Exploitation of Persons with Disabilities. Location: Michigan League, 911 North University, Ann Arbor. Sponsor: University of Michigan Medical School, Department of Physical Medicine and Rehabilitation, Kenny Rehabilitation Foundation of Michigan. Contact: Gayle Fox, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

October

1, Emergency Medicine Oral Boards Preparation Course. Location: St. Mary's Hospital, Saginaw. Sponsor: Michigan Chapter of the American College of Emergency Physicians. Contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500. Approved for: 5 hours Category I Credit.

1, AIDS and Primary Care Physicians in Michigan. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 7 hours Category I Credit.

2, Michigan Chapter American Academy of Pediatrics Annual Scientific Meeting. Location: Grand Traverse Resort and Conference Center, Traverse City. Sponsor: Michigan Chapter American Academy of Pediatrics. Contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills, MI 48018 (313)553-3646. Approved for: 7 hours Category I Credit.

3-4, Impairment Evaluation and Disability Considerations. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Surgery and Department of Physical Medicine and Rehabilitation. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 14 hours Category I Credit.

3-4, Ear, Nose and Throat Practicum. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 17 hours Category I Credit.

4, Critical Clinical Issues in the Care of the Elderly. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Internal Medicine. Contact: Betty Phillips, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 12 hours Category I Credit.

6-7, Nutritional Support: A Return to Basics and Current Day Management. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Parenteral and Enteral Nutrition Team, Section of Pediatric Surgery, Department of Surgery. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 10 hours Category I Credit.

14-15, 1988 Michigan Statewide Conference on Child Abuse and Neglect: Strategies for Successful Prevention and Treatment. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School. Contact: Debbie DeSmyther, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 11 hours Category I Credit.

17-18, The Dilemma of the Complications of Diabetes. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, The Michigan Diabetes Research and Training Center, The Michigan Affiliate of the American Diabetes Association. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 13 hours Category I Credit.

December

4-5, The Difficult Airway. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. Sponsor: University of Michigan Medical School, Department of Anesthesiology. Contact: Gayle Fox, Program Assistant, Office of Continuing Medical Education, Towsley Center, Box 0201, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 12 hours Category I Credit.

MEETINGS

MSMS MEETINGS

July

14-17, MSMS Board of Directors Midsummer Meeting, Shanty Creek, Bellaire, contact: William Madigan (517) 337-1351.

September

14, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

October

19, 1988 Public Affairs Leadership Conference, Hilton Inn, Lansing, contact: Mary Anne Ford (517)337-1351.

November

8-10, MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent (517)337-1351.

16, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETINGS

June

26-30, AMA Annual Meeting, Chicago Hilton and Towers, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4392 (312) 645-4344.

October

5-6, AMA Seventh Annual Science Reporters Conference, Westin St. Francis Hotel, San Francisco, contact: AMA, 535 North Dearborn St., Chicago 60610 (312)645-4344.

December

4-7, AMA Interim Meeting, Dallas, TX contact: AMA, 535 North Dearborn St., Chicago 60610 (312) 645-4344.

MICHIGAN SPECIALTY SOCIETY MEETINGS

June

17-19, Annual Meeting—Michigan Association of Neurological Surgeons, Grand Traverse Resort, Traverse City, contact: William F. Chandler, MD, 1500 E. Medical Center Drive, Ann Arbor 48109 (313)936-5020.

July

21, Fifteenth Michigan Emergency Medicine Assembly—EMS Concepts 88 and Base Station Symposium, Michigan Chapter of the American College of Emergency Physicians, Hilton Shanty Creek, Bellaire, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517)332-6500.

22-24, Michigan Society of Medical Assistants Summer Seminar, Michigan Society of Medical Assistants, Holiday Inn, Dearborn, contact: Caroline Kimmel, MSMA, P.O. Box 950, East Lansing 48826-0950 (517)337-1351.

25, 42nd Annual Scientific Assembly, Michigan Academy of Family Physicians, Grand Traverse Resort, Acme, contact: Julie L. Nelson, Administrative Assistant, 109 East Oakland, Lansing 48906 1-800-833-5151.

August

19-20, Michigan Society of Thoracic Surgeons Annual Scientific Meeting, Grand Hotel, Mackinac Island, contact: Luis A. Tomatis, MD, President, 21 Michigan Street, N.E., Suite 550, Grand Rapids 49503 (616) 459-6577.

October

2, Michigan Chapter, American Academy of Pediatrics Annual Scientific Meeting, Grand Traverse Resort and Conference Center, Traverse City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018 (313)553-3646.

9, Emergency Medicine Oral Boards Preparation Course, Michigan Chapter of the American College of Emergency Physicians, St. Mary's Hospital, Saginaw, contact: Catherine C. Sleicher, 1305 Abbott, Suite 104, East Lansing 48823 (517) 332-6500.

NATIONAL SPECIALTY SOCIETIES

June

20-23, American Orthopaedic Association Annual Scientific Meeting, The Homestead, Hot Springs, VA, contact: American Orthopaedic Association, 222 S. Prospect Avenue, Park Ridge, IL 60068 (312)823-7186.

August

23-26, The American College of Physician Executives, The American Academy of Medical Directors First Executive Symposium on Health Care Management, Four Seasons Hotel, Vancouver, British Columbia, contact: The American College of Physician Executives, One Urban Centre, 4830 West Kennedy Boulevard, Suite 648, Tampa, FL 33609-2517 (813)287-2000.

September

14-17, American Group Practice Association Annual Meeting, Hotel Intercontinental, San Diego, CA, contact: American Group Practice Association, 1422 Duke Street, Alexandria, VA 22314 (703)838-0033.

23-24, American Academy of Facial Plastic and Reconstructive Surgery Annual Meeting, Washington, DC, contact: American Academy of Facial Plastic and Reconstructive Surgery, 1101 Vermont Avenue, N.W., Suite 404, Washington, DC 20005 (202)842-4500.

26-29, American College of Emergency Physicians Scientific Meeting, New Orleans Convention Center, New Orleans, LA, contact: American College of Emergency Physicians, P.O. Box 619911, Dallas, TX 75261-9911 (214)550-0911.

October

1-6, American Academy of Family Physicians Annual and Scientific Meetings, New Orleans Marriott, New Orleans, LA, contact: American Academy of Family Physicians, 1740 W 92nd Street, Kansas City, MO 64114 (816)333-9700.

3-7, American College of Chest Physicians Scientific Meeting, Anaheim Hilton, Anaheim, CA, contact: American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068 (312)698-2200.

8-12, American Academy of Ophthalmology Annual Scientific Meeting, Las Vegas, NV, contact: American Academy of Ophthalmology, P.O. Box 7424, 655 Beach, San Francisco, CA 94120 (415)561-8500.

8-12, American Society of Anesthesiologists Annual Meeting, San Francisco Hilton, San Francisco, CA, contact: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, IL 60068 (312) 825-5586.

17-19, American College of Gastroenterology Annual Meeting, Hilton, New York, NY, contact: American College of Gastroenterology, 13 Elm Street, Manchester, MA 01944 (617)927-8330.

23-28, American College of Surgeons Annual Meeting, Hilton, Chicago, IL, contact: American College of Surgeons, 55 E. Erie Street, Chicago, IL 60611 (312)664-4050.

26-30, American Academy of Child and Adolescent Psychiatry Annual Meeting, Westin Hotel, Seattle, WA, contact: American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, N.E., Washington, DC 20016 (202)966-7300.

30-11/4, American Academy of Physical Medicine and Rehabilitation Annual Scientific Meeting, Convention Center, Seattle, WA, contact: American Academy of Physical Medicine and Rehabilitation, 122 S. Michigan Avenue, Suite 1300, Chicago, IL 60603 (312)922-9366.

31-11/5, American Academy of Pediatrics Annual Meeting, San Francisco, CA, contact: American Academy of Pediatrics, 141 Northwest Point Road, P.O. Box 927, Elk Grove Village, IL 60007 (312)288-5005.

November

12-16, American College of Allergists Annual Scientific Meeting, Westin Century Plaza, Los Angeles, CA, contact: American College of Allergists, 800 E. Northwest Highway, Suite 101, Mt. Prospect, IL 60056 (312)255-0380.

OTHER MEETINGS

June

23-25, Helping Heal the Whole Person and the Whole World, A Global Conference, Sponsored by the John E. Fetzer Foundation, Kalamazoo, contact: Dr. Michael E. Morton, John E. Fetzer Foundation, 9292 West KL Avenue, Kalamazoo 49009 (616)375-2000.

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AMILY PHYSICIAN to replace retired member of ve person busy suburban practice. OB optional, experience desirable. Contact John P. Newton MD, Plainfield Medical Center, Grand Rapids, Ml 49505. Phone (616)364-7015.

ANESTHESIOLOGIST to join group consisting of 4 anesthesiologists and 3 CRNA's. Must be board eligible or board certified. Established PC with many fringe benefits in effect. Send CV to Associated Anesthesiologists of Saginaw, PC, 3121 Davenport, Saginaw, Michigan 48603 or call (517) 791-2150.

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ENT A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible otolaryngologist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospitals has a medical staff of 45 fulltime physicians and a total service area population of over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals. 400 Woodward Avenue, Iron Mountain, Michigan 49801. (906)779-4502.

EMERGENCY ROOM PHYSICIAN Michigan, Upper Peninsula hospital based emergency department located in a resort area with 15,000 visits annually. Immediate opening for one full-time physician. Applicants must be ACLS certified with previous emergency department experience. Competitive salary with malpractice paid and benefits. Excellent hunting, fishing and outdoor recreational area. Interested applicants send CV with home phone number to Dr. Robert J. Trethewey, Dickinson County Memorial Hospitals. 400 Woodward Avenue, Iron Mountain, Michigan 49801. (906) 779-4555.

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DETROIT SUBURBAN extended-hour family practice and industrial medical clinic needs licensed MD. Internal medicine, emergency room and family practice, with minor surgery experience will be considered. Part- and full-time position available. Salary plus excellent incentive bonus. Send C.V. to: S. L. Kiwak, Administrator, 1500 Eureka Road, Wyandotte, MI 48192.

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Continued on next page

CLASSIFIED/Continued

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ORTHOPEDIC SURGEON A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible orthopedic surgeon to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital's have a medical staff of 45 full-time physicians and a total service area over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801 (906)779-4502.

PSYCHIATRIST A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible psychiatrist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospital's has a medical staff of 45 full-time physicians and a total service area population of over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801. (906)779-4502.

DERMATOLOGIST A progressive 131-bed two-hospital system is seeking a Board certified or board eligible dermatologist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin, Dickinson County Hospital's has a medical staff of 45 full-time physicians and a total service area population of over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals. 400 Woodward Avenue, Iron Mountain, Michigan 49801. (906) 779-4502.

NEUROLOGIST A progressive 131-bed two-hospital system is seeking a Board certified or Board eligible neurologist to establish a practice in the Iron Mountain area of Michigan's beautiful Upper Peninsula. Located 100 miles directly north of Green Bay, Wisconsin. Dickinson County Hospitals has a medical staff of 45 full-time physicians and a total service area population of over 40,000. For more information, contact John Schon, Vice President, Dickinson County Hospitals. 400 Woodward Avenue, Iron Mountain, Michigan 49801. (906) 779-4502.

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Family Practice Recertification	382
Farmbrook Medical Centers	IFC
Hosp. & Health Serv. Credit Union	367
Group Health Inc.	368
Lab of Clinical Medicine	385
Lilly	397
M-Labs	363
Medical Billing Service	351
Methodist Hospital	386
Metric Labs	369
Miles Laboratory	379-380
MPMLC	387
Palisades Pharmaceutical	373
Peace Corps	398
Physicians Placement Service	363
Physicians Service Group (PSG)	333
PICOM	347
Roche	398, IBC, BC
Sinai Hospital	368
Savage	353-354
Stratton-Cheeseman	392
Trans Global Tours	377
U.S. Air Force	383

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"Here he comes — ready or not!"

Everything is relative

By Frederick W. Bryant, MD

> "Medicine is on a maintenance diet, and the government counts the calories. Any gain will be accompanied by a corresponding loss."

Once upon a time all doctors took care of all ailments.

There was relative accord, with common perspectives. As mankind's knowledge burgeoned, new avenues opened, the profession multiplied and divided. We compartmentalized the body in thought and deed, effectively packaging expert care for every medical minutia. The Golden Age of Specialization was upon us. Scientifically, it seemed perfect.

But not all was well; Eden was overcast. Physicians lost the grand view, slipping into insular expertize and cubby-hole communication. In isolated grandeur there was reason for suspicions of inequality and envy. Doctors asked, "How am I doin' compared to the rest?" and "Am I rewarded fairly for my labors?"

Doctor Bryant

Currently a Relative Value Scale at Harvard University ponders the worth of physicians' services and procedures, comparing values within various specialties, then crossing specialty lines, striving ultimately to link all to a single grand index. The complex project considers the time necessary to perform a task, cost of post-graduate training to become a qualified specialist, practice expense (including malpractice costs), and intensity. Intriguingly, the latter is comprised of mental effort, knowledge, judgement and diagnostic acumen, technical skill, physical effort, psychological stress, and potential risk to patient and physician. All this will provide new handles for old rivalries. Some of us will find comfort and justice in it.

Interestingly, instigation and impetus for the study came from HCFA, the federal government's major-domo which parcels out payments to physicians. With a mood bent on reduction of costs at all costs, there is little largesse. The economic pie will not grow. Medicine is on a maintenance diet, and the government counts the calories. Any gain will be accompanied by a corresponding loss. No matter how we slice it, not all will be satisfied. There may even be medical malnutrition, where recruits at Medicine's table choose to desert it.

The AMA uneasily awaits release of the study, resolving to review it carefully, then advocate what is best for all in the long run.

Individual and specialties, too, should react sensibly. We must be careful how we ingest this seemingly innocent, attractive new apple in Eden. Medicine needs the grand view now. We must beware the disadvantages of division and dissension, and act together to retain as much of Paradise as possible. ☐

Doctor Bryant is MSMS president.

A NEW H_2 Antagonist

AXID® 300mg

nizatidine

Effective once-nightly
duodenal ulcer therapy available in a

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for better patient compliance

AXID®
nizatidine capsules

Brief Summary. Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer In most patients, the ulcer will heal within four weeks

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s after healing of an active duodenal ulcer The consequences of continuous therapy with Axid for longer than one year are not known

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists

Precautions: *General*—1 Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy

2 Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency

3 Pharmacokinetic studies in patients with hepatorenal syndrome have not been done Part of the dose of nizatidine is metabolized in the liver In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects

Laboratory Tests—False-positive tests for urobilinogen with Multistix* may occur during therapy with nizatidine

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations) The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus There are, however, no adequate and well-controlled studies in pregnant women It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers

Pediatric Use—Safety and effectiveness in children have not been established

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups Age alone may not be an important factor in the disposition of nizatidine Elderly patients may have reduced renal function

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0 2%), urticaria (0 5% vs <0 01%), and somnolence (2 4% vs 1 3%) were significantly more common in the nizatidine group A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients All abnormalities were reversible after discontinuation of Axid

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo Rare reports of gynecomastia occurred

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist On previous occasions, this patient had experienced thrombocytopenia while taking other drugs

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients Rash and exfoliative dermatitis were also reported

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported

Overdosage: There is little clinical experience with overdosage of Axid in humans If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy Renal dialysis for four to six hours increased plasma clearance by approximately 84%

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively PV 2091 AMP [041288]

Axid* (nizatidine, Lilly)

Lilly

Eli Lilly and Company
Indianapolis, Indiana
46285

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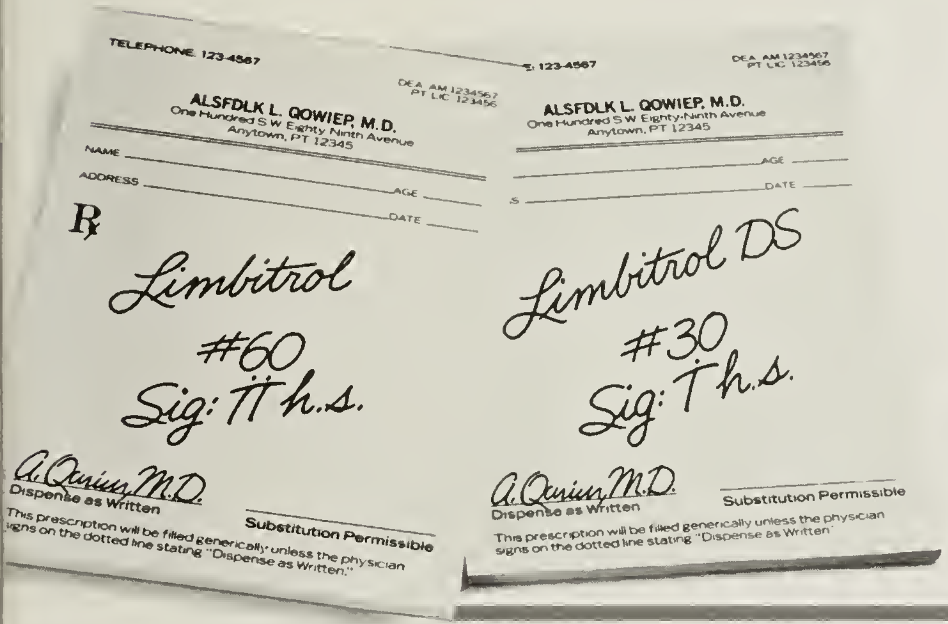
In moderate depression and anxiety

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



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DEA AM 1234567
PT LIC 123456

ALSFDLK L. QOWIEP, M.D.
One Hundred S W Eighty Ninth Avenue
Anytown, PT 12345

NAME
ADDRESS AGE
DATE

℞

Limbitrol
#60
Sig: ii h.s.

A. Quinn, M.D.
Dispense as Written
Substitution Permissible

This prescription will be filled generically unless the physician signs on the dotted line stating "Dispense as Written."

E: 123-4567

DEA AM 1234567
PT LIC 123456

ALSFDLK L. QOWIEP, M.D.
One Hundred S W Eighty-Ninth Avenue
Anytown, PT 12345

AGE
S DATE

Limbitrol DS
#30
Sig: i h.s.

A. Quinn, M.D.
Dispense as Written
Substitution Permissible

This prescription will be filled generically unless the physician signs on the dotted line stating "Dispense as Written"

Protect Your Prescribing Decision: Specify "Do not substitute."

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓘⓥ

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓘⓥ

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

Limbitrol® Ⓒⓥ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.
Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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In the depressed and anxious patient

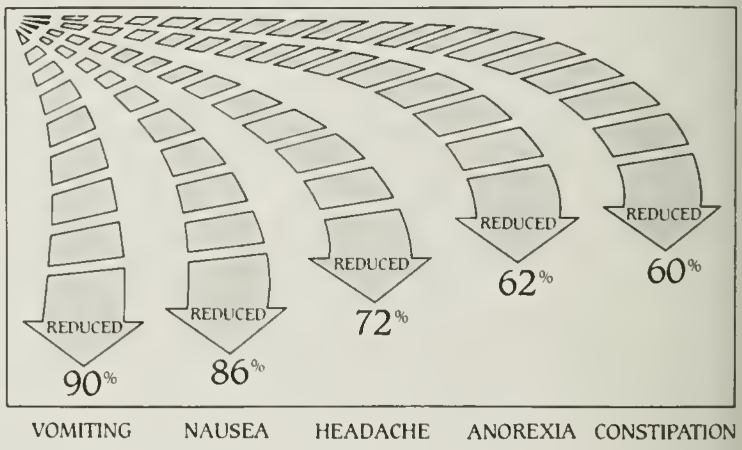
See Improvement In The First Week[1]...

And The Weeks That Follow

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week reduction in somatic symptoms[1]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓘⓥ

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓘⓥ

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